How will we care?
Finding sustainable long-term care solutions for an ageing world
Executive summary

By 2030, there will be more than 1 billion people aged 65 and over.

The world is getting older. Over the next 20 years the number of people aged 65 and above will increase by 80% to nearly 1 billion. This major demographic shift will generate increased demand for care services in all parts of the world.

The provision and funding of care services for the elderly will be one of the most pressing issues facing society, driven by various demographic and societal trends.

The financing and provision of effective care services for the elderly will be one of the most challenging issues facing society, driven by various demographic and societal trends. Public spending on long-term care (LTC) will increase significantly in the coming decades, straining government budgets in advanced economies. In emerging markets, public finances are less stressed but the low starting point of LTC spending and the immense growth of funds needed will still be a huge challenge.

Care needs for the elderly progress with age from assistance for an active life to, potentially, 24-hour care.

In the past, care for the elderly has tended to be thought of only in terms of advanced-stage institutional care. Today, a fundamental premise of care services is to help people live at home for as long as they can. The care services continuum begins with providing the required assistance to help the recent retiree maintain an active and independent life. The services then progress to additional support (sometimes institutional) to manage the increasing mental and physical incapacities that come with age, and may culminate in 24-hour care.

The burden of care will increasingly fall on private individuals.

Private individuals in both advanced and emerging markets will increasingly need to shoulder the burden of providing care services for the elderly. Already today, where public provisions are not comprehensive (many advanced markets), or are unavailable (most emerging markets), care is mostly financed out-of-pocket.

To date, various supply- and demand-side issues have held back the development of a large-scale private LTC insurance sector.

The contribution of private insurance is typically less than 2% of total LTC spending, and the experience so far has been mixed. Various issues influence the lack of success of a private insurance market. For example, on the supply side a dearth of experience data makes provision of insurance solutions difficult. Traditional LTC insurance is very long-term and requires a number of forward-looking assumptions which, due to changing market and social policy conditions, complicate the provision of LTC insurance. Adverse selection can also be an issue. On the demand side, there is a general lack of consumer awareness of complex and difficult-to-understand LTC risks. Behavioural and cognitive biases also play a role in directing consumers to sometimes make non-optimal LTC choices.

This can change. Private insurance can be part of an integrated, multi-stakeholder ...

However, private insurance can and should play a role in future LTC solutions by being part of an integrated, multiple stakeholder (insurers, governments, healthcare institutions, care providers and consumers), and financially sustainable solution. This sigma reviews various options to meet the challenge of the ageing population’s care needs. These include private insurers becoming investors in care infrastructure and services, and more involvement of employers in raising awareness of LTC risks. There also needs to be stronger coordination of the different agents involved in care delivery and a promotion of healthy-ageing initiatives. Other options could be state incentives to encourage and support family members to become home carers, and more investment in technological innovation to enable better health monitoring, care coordination and a longer period of living at home.

... and financially sustainable LTC solution.

There is also scope for private insurance solutions to better meet consumers’ needs. To take advantage of this business opportunity, some insurers are reconsidering product design, developing new products and introducing hybrid-type solutions that combine LTC insurance with life, retirement/pension and critical illness products.
Introduction

"Ageing is not lost youth but a new stage of opportunity and strength." – Betty Friedan

The coming “silver tsunami”

Population greying is a near universal issue which doomsayers foretell will bring about widespread global economic and social disruption over this century. While such gloomy predictions are more the subject of dystopia movies than insurance industry debates, population ageing is a global reality. The expanding pool of elderly will require more care, something for which society should and, in partnership with insurers, can prepare. But what exactly are the health and ageing developments that will lead to care needs over the next 10–15 years? Where are the greatest threats hidden in caring for an older population? What (long-term) care solutions and related opportunities are available for insurers amid the challenge, and why has the market not already jumped at the prospect? This sigma explores the topic in detail. ¹

The era of most-rapid ageing will in many countries take place over the next 20 years. Birth rates have declined significantly over the past several decades, and life expectancy has risen. These developments are not solely an advanced world phenomenon. Emerging countries are ageing too and at a much faster pace, a challenge given that many of these countries are growing old before getting rich.

The world’s old-age population is set to increase dramatically (see Figure 1). By 2030, the number of people in the 65–79 and 80+ age groups will increase to nearly 1 billion (from around 530 million in 2010). The “oldest” regions today – Europe and Japan – will see the smallest percentage increase, while in Latin America and Asia the number of people aged 65 and over will nearly double. The absolute rise in the number of elderly and the speed of the change present severe challenges.

Source: United Nations, Department of Economic and Social Affairs, Population Division (2013), medium-fertility scenario.

¹ This sigma will focus on the care needs of the ageing. It will not cover the topic of retirement income which was discussed extensively in sigma 4/2008: Innovative ways of financing retirement, Swiss Re (2008). Other Swiss Re reports on related topics include A short guide to longer lives (2010), A window into the future (2011), and A mature market (2012).
A growing need for (long-term) care solutions

As the number of elderly rises, so does the need for funding and provision of long-term care (LTC) services. Advanced and emerging markets will need to manage the costs of caring for the elderly as their health deteriorates due to chronic disease, disability and cognitive impairments. According to a study by the Bank of International Settlements, advanced market governments are already constrained by their public debt burdens. Future promises of age-related spending (retirement and retiree healthcare costs) are often huge, amounting to a multiple of the explicit government debt. A 2010 report concluded that “without sweeping changes to age-related public spending, sovereign debt will soon become unsustainable”. In emerging markets, a sharp rise in public spending on LTC is expected even though formal social protection systems do not yet exist or cover only a small proportion of the older population.

Other demographic trends are compounding the overall care solutions challenge. Even in advanced countries, unpaid informal care by families is currently often the largest contributor to care solutions. Meanwhile, the availability and accessibility of informal care is increasingly constrained, particularly in emerging markets, where the family has traditionally provided care outside of acute care settings. In India and China, the percentage of older people living in multi-generational households with their adult children is 82% and 69%, respectively, compared with fewer than 10% in parts of Western Europe. However, urbanisation, higher female labour force participation and lower fertility rates do not bode well for the future of informal care in emerging markets. For example, in China a 4-2-1 family structure, where one child may have to care for two parents and four grandparents, is increasingly common. Similarly, in India, the migration of the younger generations from rural to urban areas is weakening older persons’ traditional support systems. Additionally, in a global Swiss Re survey of more than 22 000 respondents, individuals from emerging markets showed a relatively low willingness to provide care for their parents or partners, presenting another challenge to the family care model. The shrinking of working-age populations in many advanced and emerging countries also begs the question of who should provide care in the future.

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The ageing population and its care needs

The level of overall care needs will depend on whether increased longevity comes with added healthy life years. If increasing longevity comes with added healthy life years – known as compression of morbidity – the level of overall care needs might be lower in the future, despite a larger older population. However, if the same number of years is spent in ill health, just at a later age (postponement of morbidity), or if more years are spent in ill health (expansion of morbidity), then the overall care needs outlook is more challenging.

Morbidity varies from country to country... The debate between the compression, postponement and expansion of morbidity is far from resolved. Advanced world evidence points to compression in at least some cases. However, large variations exist from country to country, and population-wide studies may mask significant trends through time and in sub-groups of societies. For example, a recent study in New York City found that limitations to cope with daily self-care were associated with lower income. Other studies have found that the higher the level of education, a proxy for socioeconomic status, the lower the disability rates.

... and even among sub-groups of societies within the same country. For low- and middle-income countries, data is harder to come by. A study in the city of São Paulo showed that from 2000 to 2010, persons aged 60–64 gained two years of life but lost three years of life expectancy in good health. Additionally, World Health Organization surveys in five emerging markets found that better-educated and wealthier people in each country have a significantly lower decline in health condition from one survey period to the next. Another complication is the difficulty in predicting the effect of conflicting population health trends, such as increasing obesity and a declining number of smokers.

Generally speaking it is the "oldest of the old" who experience a high rate of disability and dependency. Care needs assessment – what triggers dependency?

Importantly, older lives are not defined by calendar age, but rather by the level of health or disability. The variance of health and disability conditions among the elderly can be huge, with some already “old” at age 60 while others remain active and fit beyond 80+. For example, the oldest competitor to date to finish an Ironman race was a youthful 82! Generally speaking, however, it is the “oldest-of-the-old” who experience the highest incidence of disease and co-morbidity, and a high rate of disability. These conditions are linked to functional dependency and needing help with a range of self-care activities.

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11 Health of Older Adults in New York City Public Housing, New York City Housing Authority Senior Survey, (2010).
15 R. Fauteux, “Sister Madonna Buder Ironman Triathlon finisher at 82-years-old: A world record”, The Examiner, 28 August 2012. The Ironman is a triathlon race including a 2.4-mile swim, 111-mile bike ride and a 26.2-mile run.
The support provided to people as they lose the ability to care for themselves due to chronic disease, disability or cognitive impairments can be categorised as “care services”. These encompass a broad range of health and health-related services, combining medical, social and community aspects, alongside traditional LTC in institutional settings. The various components are not clearly delineated and often overlap. As care needs vary in setting, level and scope, the services to address them need to be diverse and dynamic.

Traditionally, care services and solutions\(^ {17} \) have focused on advanced care needs in institutions. But the funding and service delivery for advanced care has not been aligned with other stages of care needs, nor is it coordinated with the general healthcare and social services that are an integral part of addressing overall care needs. It would be better if care for the elderly was seen as an integral part of broader health. Also, consumer and care-system preferences are shifting to providing care closer to home, which will likely require a wider range of care solutions to suit the diverse needs of older individuals.

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17 Care solutions refer to care insurance products that help address care needs of the elderly.
The ageing population and its care needs

The early care needs are typically linked to chronic disease management, or to early treatment of well-controlled conditions (see Figure 2). At a more advanced stage, dependency, and thus a need for care, is often measured using a classification system that assesses an individual’s ability to do daily activities. More specifically, the classification distinguishes between activities essential for independent living (activities of daily living, or ADL) and those that are “instrumental” activities of daily living (IADL). These are more complex activities requiring a higher level of personal autonomy (see Figure 3).  

Normally, the ability to perform IADL declines before ADL incapacities occur and these IADL limitations are considered representative of early care needs. The degree of dependency on ADL/IADL scales is determined by qualified/certified staff and in some cases, the list of ADL evaluated far exceeds the sample list in Figure 3. For example, in Korea 52 separate components in five categories are evaluated under ADL. The fewer ADL/IADL an individual can perform, the higher his/her dependency.

Other criteria for determining dependency, such as hours of help required per week, are also used in some countries. Cognitive impairments can also lead to dependency and are in fact becoming a leading cause of dependency, although not all classifications systems recognize these as a trigger.

**Figure 3:** The ADL/IADL measures for assessing dependency

<table>
<thead>
<tr>
<th>ADL</th>
<th>IADL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Housework</td>
</tr>
<tr>
<td>Dressing</td>
<td>Money management</td>
</tr>
<tr>
<td>Walking/moving</td>
<td>Medication adherence</td>
</tr>
<tr>
<td>- unassisted from</td>
<td>- Shopping</td>
</tr>
<tr>
<td>- bed to wheelchair</td>
<td>- Getting around outside the house</td>
</tr>
<tr>
<td>Feeding</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
</tr>
<tr>
<td>Continence</td>
<td></td>
</tr>
</tbody>
</table>

Source: Swiss Re Economic Research & Consulting.

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Key risk factors associated with old-age disability

The underlying causes of old-age disability vary across individuals and populations. The most commonly identified risk factors for old-age disability are: demographics, health conditions, behaviour and lifestyle choices, and social support, along with the already-mentioned socio-economic status.

Demographics: Age has been found to be the most important risk factor for old-age disability. Advanced ageing causes changes in bodily structures and functions and is a strong and consistent predictor of functional disability. Gender differences in old-age disability are substantial, with women facing a higher risk of becoming disabled and facing disability for longer durations.

Health conditions: Chronic diseases, such as hypertension, diabetes and arthritis are linked to disability and dependency globally, along with cancer and strokes. In emerging markets, where assistive devices and treatment are less readily available, vision, hearing and mobility are also considered to be key ageing issues. Cognitive impairments can also result in dependency and are expected to contribute significantly to future LTC needs growth. Cognitive impairments may arise due to Alzheimer’s and similar forms of irreversible dementia and require substantial supervision to protect the dependent from threats to health and safety. Poor self-rated health is also found to be associated with functional impairment. Similarly, chronic pain strongly increases the likelihood of ADL and IADL limitations.

Behaviour and lifestyle choices contribute to the development of disability in old age. For example, smoking and low levels of physical activity increase the risk for functional status decline, as has been shown in many studies.

Social support: Both the quantity and quality of social support significantly affect the development of old-age disability. As a measure of social support, marital status has been found to be an important factor associated with disability in western countries, with the unmarried having a higher risk of disability. Similarly, a low frequency of social contact has been associated with poor physical functioning.

Care needs for the elderly range from supporting independent living to providing 24-hour care. The starting point is a relatively independent and active retiree with an early diagnosis of minor conditions. Here the focus is on preventing health from declining and providing additional social care. Both are crucial. The next stage is when the retiree begins to need help with a few of the IADL. Thus, some home support is required, for example with cooking or cleaning. After failing multiple ADL, additional help is needed. Finally, round-the-clock care and even formal institutional care may be necessary. The health, social and behavioural conditions of a person are all factors in determining an individual’s needs and should be considered as part of the entire scope of assistance provided during all stages of the care continuum.

Effective (long-term) care solutions will be one of the biggest challenges facing society in the coming decades, and policymakers will need to find balanced solutions that are equitable, fair and sustainable. Private insurance can and should play a role in funding and managing LTC risks. However, private LTC insurance has had a limited impact in the past, which raises the question of how exactly insurers can increase their support to societies in managing LTC-related risks and costs.

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Long-term care today

Financing of long-term care today

Traditionally, care services and solutions have focused only on the more advanced care needs stages – or LTC. In 2008, total public and private expenditure on LTC in OECD countries averaged 1.5% of gross domestic product (GDP). There was significant cross-country variation in spending ranging from a low of around 0.2% of GDP to a high of 4%. This reflects differences in care needs and their definition, in the comprehensiveness of formal LTC systems, and in the culture of care and the associated role of the family in specific societies.

The sources of LTC financing also vary significantly across countries (see Figure 4). For example in the Nordic European countries, LTC is an integral part of the welfare systems that provide universal coverage and most LTC needs are publicly financed (through taxes or social insurance). In other OECD countries like the US and the UK, access to public financing for LTC is means-tested to ensure that only the neediest in society have access. Mixed systems that combine universal and means-tested LTC entitlements are also common in OECD countries (eg, France, Italy, Portugal and New Zealand).

Note: Data on out-of-pocket spending for some of the countries are underestimated. For example, in the Netherlands, cost sharing on long-term care services is estimated to account for 8% of the total LTC expenditure. The share of out-of-pocket spending for Switzerland is overestimated as cash benefits granted for care in care facilities are not considered.


In most OECD countries, LTC is primarily financed through government programs.

Where public schemes are not comprehensive or are unavailable, LTC is financed mostly by out-of-pocket payments and private insurance. Out-of-pocket payments in some countries are substantial. The contribution of private insurance, on the other hand, is typically less than 2% of total LTC spending.

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22 Total expenditure includes both public and private expenditure for home and institutional LTC. The study did not cover all OECD countries. See F. Colombo et al., “Help Wanted? Providing and Paying for Long-Term Care”, OECD Publishing, (2011).

23 Although out-of-pocket payments may include co-payments of public LTC schemes.
Official statistics and public data tend to omit a huge chunk of LTC costs. In many countries, the majority of care is provided informally by unpaid family members, often dwarfing formal expenditure. In the US, for instance, the economic value of such informal care was estimated to be some USD 234 billion in 2011, which was about 55% of the total spending on LTC of USD 426 billion that year, and equivalent to 1.5% of GDP.\(^{24}\) In the UK, the economic value of the unpaid informal care provided by family, friends and neighbours is estimated to be GBP 119 billion per year (USD 184 billion).\(^{25}\) or 8% of GDP and well in excess of the entire National Health Service (NHS) budget of GBP 98.8 billion for the year 2009–2010.\(^{26}\) In Canada, informal caregivers provide about 80% of the care for people with chronic health issues, contributing an estimated economic value of CAD 25 billion (1.4% of GDP).\(^{27}\)

In emerging markets formal government-financed LTC schemes are rare. According to the OECD, average spending for public LTC was 0.1% of GDP in the BRICs (Brazil, Russia, India, Indonesia, China and South Africa – 48% of global population) compared to 0.8% in OECD countries.\(^{28}\) The informal/family care sector is often the only option for those in need of care. The lack of a formal sector is partly rooted in cultural differences such as the established role and responsibilities of the family and the state: in many emerging markets, the state has rarely provided a safety net of any kind. Another reason is that the rapid demographic and economic developments in emerging markets in recent years have outpaced the implementation and funding of formal LTC schemes and infrastructure.

Spending on public plans in the advanced world will increase from 0.8% of GDP in 2010 to between 1.2% and 1.4% of GDP by 2030, the OECD says. Given strained public finances and competing needs, policymakers will have to make difficult decisions. In emerging markets, public finances are less strained but the low starting point of LTC spending (0.1% of GDP) and the immense growth of the funds required (between 0.5 and 0.6% of GDP by 2030) will be a huge challenge. Ultimately, the burden on individuals will increase in both the advanced and emerging markets. They already pay for a large chunk of their own LTC needs. They will need to pay more.

**Provision of long-term care**

Funding is not the only area of concern. So too is availability of LTC infrastructure and formal and informal care providers. Today, around 70% to 90% of those who provide care are family members, and 90% of all home care is provided informally without compensation.\(^{29,30}\) For example, in Europe children, children-in-law and spouses make up more than 75% of carers.\(^{31}\) Similarly, in Japan informal care by adult children or children-in-law is the most common source of care for the elderly, in accordance with the traditional Japanese social norms. In Singapore, more than 75% of caregivers are spouses and children, and about 14% of caregivers are maids.\(^{32}\) Semi-trained domestic workers or maids from developing countries are also common home helpers for the elderly in countries such as Hong Kong and parts of Europe.

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\(^{25}\) In this and all other cases in this report, unless otherwise specified, the exchange rate used is the year-average for the year of the data point.

\(^{26}\) *Valuing Carers 2011 – Calculating the value of carers’ support*, Centre for International research on Care, Labour and Equalities, University of Leeds, (2011).

\(^{27}\) *CLHIA Report on Long-Term Care Policy, Improving the Accessibility, Quality and Sustainability of Long-Term Care in Canada*, Canadian Life and Health Insurance Association, (2012).


\(^{30}\) Informal care-givers may still receive social transfers conditional on providing care and possibly, in practice, some informal payment from the person receiving care.


Long-term care today

Often this is the preferred form of receiving care, and in many cases also the only one available.

The widespread use of informal care is due to many reasons. First, from the dependants’ point of view, care at home is often the preferred means of receiving support.\(^{33}\) But admittedly, in many countries it is also the only source of care available. Meanwhile in some countries — for example in France, Germany, Korea, China, India, many states in the US, Ontario in Canada, and Brazil — adult children, children-in-law or families are by law responsible for their dependent parents.\(^{34}\) This is called filial piety, a value ingrained in many societies and a law in others.

Demographic trends point to a growing scarcity of informal carers.

However, demographic trends point to a decline in the pool of potential caregivers. The informal care sector will likely not be able to keep pace with growing care needs. This shortage of supply may result in a shift towards the more expensive formal sector. However, in many advanced countries the number of nursing home beds and qualified caregivers is already scarce today. In emerging markets the situation is often worse. Increasing the formal LTC supply will require significant investment from already-strained government budgets.

Capacity of residential care homes is also limited and there is a shortage of qualified carers.

For example, in China there were 39 904 residential care homes in 2010,\(^{35}\) providing a total of 3.2 million beds,\(^{36}\) capacity for just 1.5% of the 180 million persons above age 65. Moreover, it is estimated that China requires at least 10 million trained elder care workers and that currently, only a small proportion of caregivers are suitably qualified.\(^{37}\) Elsewhere, in Brazil nursing homes exist almost only in major metropolitan areas and are mainly supported by religious institutions. The state of São Paulo, for example, with more than 3.5 million old-aged people, has only 4 500 registered nursing home beds.\(^{38}\) In Malaysia, a country of 28 million people, currently just three public and one private hospital offer care for older patients, and there are only 11 geriatricians in the country, most in Kuala Lumpur.\(^{39}\) In India, where the number of elderly amounts to approximately 90 million, there were an estimated 1 444 old-age homes with a total of about 73 000 available beds in 2009.\(^{40}\) Capacity is also an issue in advanced markets, though to a lesser degree.

Financial sustainability is the most important priority for LTC systems.

Given these challenges, policymakers around the globe need to assess how to fund and provide LTC efficiently and effectively. Ensuring fiscal and financial sustainability is widely considered to be the most important policy priority for LTC systems in OECD countries.\(^{41}\) This involves decisions about whether LTC should be financed publicly or privately (or a mix of both).

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\(^{36}\) As a result of a government initiative (“Views on Speeding up the Development of Elderly Services”) the capacity of residential care homes increased strongly between 2006 and 2009 with an average additional 227 000 beds per year.


\(^{39}\) K. S. Ambigga et al., “Bridging the gap in ageing: Translating policies into practice in Malaysian Primary Care”, Asia Pacific Family Medicine, (2011).


The role of private insurance

Although LTC insurance is a tiny fraction of total L&H premium income, it can help cover dependency costs.

That LTC is rarely financed through private insurance is mirrored in very low levels of LTC insurance premium income. Of the estimated USD 2.670 billion of premiums written by life and health (L&H) insurers globally in 2014, less than 1% stems from LTC insurance, despite the huge LTC protection gap that people face.

Private LTC insurance traditionally covers the costs associated with dependency. It is ideally bought before retirement. Premium payments are accumulated and then used to pay the care costs (reimbursement-type insurance) of the insured or a fixed benefit (annuity/indemnity/income type insurance). Private LTC insurance – if available at all – coexists with countries’ public LTC systems, either to complement, supplement or substitute any available public plans (see Table 1 and the Appendix for a discussion of the major LTC insurance markets).

For instance, in Germany the mandatory private LTC insurance offers substitute cover to those who opt out of the social LTC insurance scheme. In the US, only the poor are eligible for Medicaid, while all others are responsible for their own LTC cover. Private LTC insurance is thus a primary means for LTC risk sharing. Voluntary private LTC insurance can also offer complementary/supplementary coverage for the portion of the LTC costs not covered under universal public plans, such as in France, Japan and Germany.

In practice, voluntary LTC insurance as a primary source for LTC risk sharing and financing has turned out to be far from ideal. In the US and the UK, the limitations of public plans and tough means-tests should give consumers a strong incentive to buy private LTC cover. In both countries, however, LTC insurance has not been successful and has only been purchased by a small fraction of the population. In addition, in the US, policies turned out to be incorrectly priced and resulted in major financial and reputational damages for insurers.

By contrast, insurers have been relatively more successful in selling supplementary LTC insurance like, for example, in Germany, France, Israel, and Singapore, although benefit levels are usually quite small and insufficient to cover care costs. There have been no major issues in these markets thus far but here too, traditional LTC products have also not been a runaway success and market participants continue to explore alternatives.

Note too, that the sales successes in some of these markets are not necessarily proof of concept. The first decades of deferred LTC insurance products are usually not problematic as claims are low, unless there is large selection bias. The acid test begins after the first policyholder generation reaches the age when dependency quickly rises. In this respect, it may be that the US is simply the most senior market.

Generous public systems limit the development of private markets.

Insurers have also been less successful in markets with very generous public systems, such as Japan and Korea. With the government covering a majority of the care costs, there is little incentive for consumers to purchase additional private coverage. On the other hand, subsidies for supplementary LTC insurance can incentivize consumers to buy LTC insurance and reduce their LTC protection gap (e.g., in Germany).

Singapore has adopted an interesting voluntary system.

Singapore has adopted an interesting approach, based on insights from behavioral science and aided by massive promotional campaigns, to increase participation in its ElderShield program, a private-public-partnership LTC insurance plan. At age 40 citizens by default participate in ElderShield, but have the right to opt-out. Moreover, premiums for ElderShield can be paid out of medical savings accounts, which are funded by salary deductions and for which young healthy people often find few other ways to spend the money as it is not available for non-medical purposes.
Table 1: Market size and private/voluntary LTC insurance in countries with significant private LTC insurance

<table>
<thead>
<tr>
<th>Total paid LTC costs (2011, USD billion)</th>
<th>Public LTC</th>
<th>Private LTC insurance</th>
<th>Typical annual premium rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Type of public LTC scheme</td>
<td>% of total LTC</td>
<td>Premium volume (2012, USD million)</td>
</tr>
<tr>
<td>US</td>
<td>Means-tested safety net (Medicaid, assets &lt;USD 2,000)</td>
<td>71%</td>
<td>11,645 (total) 9,550 (individual) 2,095 (group)</td>
</tr>
<tr>
<td>Germany*</td>
<td>Universal LTC insurance, dual system with social LTC and private LTC insurance</td>
<td>67%</td>
<td>1,085 (voluntary LTC insurance)</td>
</tr>
<tr>
<td>France*</td>
<td>Universal LTC consisting of social health insurance and a specific, means-tested LTC scheme called Allocation Personnalisée d’Autonomie (APA)</td>
<td>70%</td>
<td>8,26 (total) 5,99 (life insurers) 192 (Mutual 45) 35 (Institutions de Prévoyance)</td>
</tr>
<tr>
<td>Japan*</td>
<td>Universal social LTC insurance for those 40 and older</td>
<td>90% (45% taxes, 45% social contributions, 10% cap/flat)</td>
<td>LTC insurance data is not separately reported, may be included in private health insurance written by L&amp;H and P&amp;C companies</td>
</tr>
<tr>
<td>Israel</td>
<td>Long-Term Care Insurance Program (LTCIP) is a universal LTC scheme with loose means test</td>
<td>NA</td>
<td>710 (total) 240 (individual) 470 (group)</td>
</tr>
<tr>
<td>Singapore</td>
<td>LTC costs are financed through: (1) government subsidies; (2) ElderShield (a government-designed, privately insured scheme); (3) ElderShield supplements (top-up policies offered by private insurers on top of ElderShield), and (4) Medifund for remaining LTC costs for the needy</td>
<td>NA</td>
<td>160 (ElderShield)</td>
</tr>
<tr>
<td>UK**</td>
<td>Currently: means-tested safety net (assets&lt;USD 37–40,000) – To be introduced: lifetime LTC cost cap, LTC cost in excess of cap born by government (room and board not included in cap)</td>
<td>NA</td>
<td>220</td>
</tr>
<tr>
<td>Canada*</td>
<td>Mix of universal (for home care) and means-tested benefits (often for institutional care)</td>
<td>NA</td>
<td>99</td>
</tr>
</tbody>
</table>

Note: * Total LTC costs are based on 2008 LTC/GDP ratios; ** Public expenditure on LTC only; LC = local currency; NA=not available.
In most emerging markets, few – if any – private products are available, even though there is little in the way of public LTC insurance. In China, large insurance companies sell savings-type insurance marketed as solutions to finance LTC costs. In India, there is no market for LTC insurance. Here the backstop is the culture of mutually supportive and self-reliant families. In Latin America, a 2005 survey of 13 countries found that only Brazil had a voluntary private LTC insurance market.42

A novel approach is working its way through the legislative system in the UK. The proposal is to set a limit on the lifetime LTC costs that a person pays out of pocket. Once the limit is reached, the government takes over, eliminating the tail risk. The caveats to the system are that room and board costs are not included in the cap, nor will they be paid by the government after the cap is reached. Moreover, already strained local governments have to verify the coverage and payments for care in fulfilling the cap. Nevertheless, this set-up with no tail risk would make it easier for insurers to offer private solutions to help cover the early risks and may help broaden the types of private solutions available to help consumers with care costs.

The risks and costs of becoming dependent

Three types of information are needed to estimate the expected cost of LTC. The first deals with the probability of becoming dependent (the incidence rate), including its severity and any transitions between levels of disability. Next, the duration of dependency would ideally be available. And finally, information on the cost of care is necessary to allow insurers to calculate the expected LTC costs (ie, the average costs per insured). However, such data is not universally available.

The probability of becoming dependent

Probabilities of dependency are important for future care planning and for assessing the cost of LTC. But figures on incidence rates for the various levels of dependency on the ADL or IADL scales or other metrics are available in a few countries only, usually those with well-developed LTC insurance markets. In the US, for example, it is estimated that around 20% of the residual life expectancy at age 65 for males and 30% for females will be in a state of chronic disability.43

Dependency increases with age, with only about 10% of cases classified at the most severe level.
Prevalence rates also vary significantly according to the definition of dependency as well as its interpretation. Large variations in dependency data can occur depending on whether the ability to perform ADL is defined as with or without the use of assistive devices such as canes or walking frames. Similarly, the assessment can be based on a requirement for “total” or “partial” failure of ADL, thus impacting the experience rates. Moreover, differing experience levels are possible depending on whether or not the disability definition includes a trigger based on cognitive impairment without necessarily failing any ADL.

**Duration of dependency**

The second key driver for the total cost of care is duration of care. Again, comparative cross-country data are sparse but according to a report commissioned by UK private health insurer BUPA, the average length of stay in nursing and residential homes in the UK is around 800 days (2.2 years). However, the range is immense: about 50% of dependants die within the first 15 months after admission, while 10% are resident for more than six years. Length of stay does show some general patterns. It declines with the age at admission, and on average women stay more than one year longer than men. Those with dementia have significantly shorter lives in nursing and residential homes.

**Unit costs of care**

The third driver of care costs are the unit costs of care. The range of costs varies widely, both within and across countries.

Most dependants suffer relatively low levels of dependency, requiring a few hours of help per week, and the cost of this type of care is comparatively low. In the case of informal care provided by relatives, which is the most prevalent form, the care is often unpaid. Formal home care costs amount to the average hourly wage of a home health aide (a typical long-term care worker), multiplied by the hours of care needed. For example, in the US caregivers are paid around USD 21 per hour. In Germany, 

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Severe cases involving institutional care make up the bulk of lifetime LTC expenses.

The bulk of LTC costs are related to the most severe cases, where institutional care is required. In the US, on average around 92% of the lifetime LTC costs are incurred during episodes of severe disability which account for about 50% of disabled years. Nursing home costs are hence an important factor for expected lifetime LTC costs. As shown in Table 2, annual nursing home costs are high relative to median income and wealth. A median income in an advanced country would cover just 0.3 to 0.7 years of institutional care. In many countries, median wealth would need to be fully spent to cover nursing home costs, and in many cases it would run short.

The experience data, where available, show that severe disability has a comparatively low probability, but very high cost. In contrast to low levels of dependency (which have a high probability but low cost), a simple system of individual savings accounts is inappropriate to finance cases of severe dependency, because saving will in retrospect turn out to have been unnecessary due to the low probability of occurrence. Moreover, only a few people are that rich to be able to save enough to cover the cost of an average episode of severe LTC. This suggests LTC insurance offers significant welfare gains.

Cases of severe care are expensive and insurance for severe LTC offers significant welfare gains.

Table 2: Income and wealth compared to the cost of nursing homes

<table>
<thead>
<tr>
<th>Country</th>
<th>Retiree income* couple/male/female</th>
<th>Median income**</th>
<th>Median wealth***</th>
<th>Nursing home costs by degree of dependency</th>
<th>Number of months nursing home can be financed by median income****</th>
<th>Number of months nursing home can be financed by median wealth*****</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>32 821</td>
<td>29 056</td>
<td>44 911</td>
<td>85 000</td>
<td>42 600*</td>
<td>4</td>
</tr>
<tr>
<td>UK</td>
<td>28 045</td>
<td>25 237</td>
<td>111 524</td>
<td>43 000</td>
<td>39 550</td>
<td>6</td>
</tr>
<tr>
<td>Germany</td>
<td>40 600 /26 000 /21 500</td>
<td>27 213</td>
<td>49 370</td>
<td>54 400</td>
<td>46 700 /3 950</td>
<td>13</td>
</tr>
<tr>
<td>France</td>
<td>NA /24 383 /16 990</td>
<td>27 835</td>
<td>141 850</td>
<td>44 600</td>
<td>39 550</td>
<td>6</td>
</tr>
<tr>
<td>Canada**</td>
<td>39 886</td>
<td>34 929</td>
<td>90 252</td>
<td>36 000</td>
<td>36 000</td>
<td>12</td>
</tr>
<tr>
<td>Australia***</td>
<td>30 783</td>
<td>38 570</td>
<td>210 510</td>
<td>54 300</td>
<td>47 200 /40 100</td>
<td>9</td>
</tr>
<tr>
<td>Switzerland</td>
<td>46 286</td>
<td>47 237</td>
<td>95 916</td>
<td>116 800</td>
<td>79 500 /38 900</td>
<td>5</td>
</tr>
<tr>
<td>Japan</td>
<td>29 916</td>
<td>26 671</td>
<td>110 294</td>
<td>62 200</td>
<td>49 300 /36 400</td>
<td>5</td>
</tr>
<tr>
<td>Italy</td>
<td>25 385</td>
<td>23 451</td>
<td>138 635</td>
<td>26 400</td>
<td>24 600 /22 800</td>
<td>11</td>
</tr>
<tr>
<td>Spain</td>
<td>19 844</td>
<td>18 531</td>
<td>63 306</td>
<td>26 600</td>
<td>26 600</td>
<td>8</td>
</tr>
<tr>
<td>China</td>
<td>NA</td>
<td>5 645</td>
<td>80 23</td>
<td>15 400</td>
<td>15 400</td>
<td>4</td>
</tr>
<tr>
<td>Mexico****</td>
<td>NA</td>
<td>3 086</td>
<td>9 718</td>
<td>22 000</td>
<td>6 500 /5 600</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: all income, wealth and cost data in USD. Latest data as available between 2008 and 2013. * Assisted Living. ** In Canada “Nursing home costs” refers to copayments, which are means tested; the value shown here is the maximum copayment. Copayments vary significantly by province. *** For an individual exceeding the means-test (severe: dependent reaches cap of AUD 25 000 for care fees, mild assuming AUD 25/day care fees). **** Annual costs do not include possible registration fees of close to USD 9 000 or more.


Cases of severe care are expensive and insurance for severe LTC offers significant welfare gains.

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47 Stallard (2009), op. cit.
The private LTC insurance market is small due to various supply- and demand-side issues.

In spite of a seemingly large market opportunity for LTC insurance, the reality is that the private solutions sector is small. Private premiums are expected to be less than 1% of global life and health premiums in 2014, amounting to at most USD 20 billion. There are supply- and demand-side reasons for this.

Supply-side issues

Lack of appropriate data can impede overall care solutions and the wider development of an insurance market. In markets without notable LTC insurance sales – and this is the case in many advanced and nearly all emerging markets – the limited availability of experience data makes it harder to design and price care solution products. It is a chicken-and-egg problem: without a large market there is little experience data and without experience data, there is no market.

But even where data exists, it is not obvious how the key parameters will develop in the future. Where there have been private markets, LTC insurance has traditionally been deferred, involving many years or even decades between the design and pricing of the contract and payment of benefit. However, fixed benefit contracts require long-term assumptions about dependency incidence rates, mortality rates for healthy and disabled, lapse rates and investment income. Reimbursement-type policies require even more assumptions such as future care cost escalations and the cost implications of innovations in future care technology. In the case of a 50-year old purchasing LTC insurance, these projections must hold for 30 to 40 years, or more. It is virtually impossible to make such assumptions accurately, and any errors in doing so can cause significant losses to the insurer.

Insurers can include a safety margin in pricing to guard against assumption sensitivity, but that makes policies more expensive. Also, consumers can be put off by contractual clauses that allow insurers to raise prices on blocks of business that have not met assumptions. Finally, these long-term systematic risks are not easy to hedge and require a lot of solvency capital, another cost in providing these products.

The US experience illustrates why deferred LTC insurance with reimbursement is particularly challenging.

There is no easy work-around for the unknown future. In the US, assumptions made for past products proved inadequate, especially when it came to investment income and lapse rates. When significant losses from these contracts as a group became apparent, regulators gave insurers permission to adjust premium rates several times. However, the rate increases upset policyholders, understandably, and in many cases made the premiums unaffordable. These challenges generated ongoing financial losses and reputational damage to the US life insurance industry overall, so much so that most players eventually withdrew from the LTC market.

An imbalance of premium payments and expected benefits can result in market failures.

Insurance markets can fail in scenarios of asymmetric information and adverse selection. Where adverse selection is suspected, insurers may need to charge higher prices to make up for the potential crowding out of demand from healthy individuals. This again makes products more expensive. Brown and Finkelstein (2007) find some evidence for an imbalance between premium payments and expected benefits of LTC insurance. However, they conclude that this alone cannot explain the low levels of coverage and that demand side effects must also play a role in preventing wider uptake of LTC products.

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48 Asymmetric information occurs when one party has more or better information than the other, creating an imbalance of power and undesirable market outcomes. Adverse selection is a consequence of information asymmetries. It occurs when higher-risk people tend to buy more insurance but the insurer is unable or not allowed to account for this in the price.

49 The imbalance between premium and benefit may also be rooted in the long-term nature of insurance products which basically requires inclusion of safety margins, which again elevates the cost of insurance, see J. R. Brown, and A. Finkelstein, “Why is the market for long-term care insurance so small?”, Journal of Public Economics, vol 91 no 10, (2007), pp 1967–91.

Inadequate care infrastructure and a shortage of claims assessors stand in the way of development of the LTC insurance market.

Volatile government social policies can undermine the development of a private market.

Finally, LTC insurance is "sold, not bought", and it can be a tough sell.

A key demand-side issue is the lack of awareness.

In emerging markets, awareness for LTC risks has not yet developed.

LTC risks are complex and difficult to assess.

Other supply-side issues include inadequate care infrastructure and a shortage of healthcare professionals. Both undermine the value proposition of LTC insurance, since one may not be able to easily purchase the care services needed. The market also needs people with sufficient expertise to act as claims assessors. For example, when ElderShield in Singapore was set up, a panel of expert assessors and a set of guidelines were needed to ensure consistency in the assessment of dependency.

Developing and providing solutions for LTC also requires a consistent regulatory and social policy landscape over a long period. If government-provided social insurance policies affecting the elderly are subject to frequent changes, insurers will be more hesitant to make the required investments into care solutions.

Finally, LTC insurance belongs to a class of products that are in general "sold, not bought." Many companies have struggled with the challenges of training a sales force for LTC solutions. Younger sales people are generally less able to sell LTC products than older agents. Moreover, LTC insurance competes with other "off-the-shelf" products in the L&H sector. In an environment of large protection gaps, life, disability, critical illness and/or medical insurance products are generally easier to sell than LTC insurance.

Demand-side issues

Demand-side issues also hinder the uptake of private LTC insurance. A main issue is lack of awareness around the risks and costs of LTC. People of working age rarely think about their end-of-life needs, since challenges 50 years in the future are too remote and rank very low on their list of priorities. A study from the UK demonstrates that even older-aged couples do not discuss their end-of-life care and how to pay for it. People tend to procrastinate on solutions. Discussion on the retirement of the baby-boomers was only fully underway in the 1990s, about 20 years before they were to retire. If the same lead time is applied, the baby-boomers will be seriously talking about LTC when they are 20 years away from needing care, or over the next 5 to 10 years. But it is already late since available solutions are mostly pay-as-you-go programs. Thus, the burden of caring for the baby-boomers may have already shifted to their children.

Lack of awareness is also a likely reason for low LTC insurance demand in emerging markets. These countries have seen fundamental economic, demographic and societal shifts in the last few decades, changes that happened over a period of 150 years in advanced markets. The needs awareness in the emerging markets has not kept pace.

LTC risks are complex. For consumers it is hard to assess the magnitude of their risks and hence to judge the value proposition of LTC products. When presented with complex financial choices, consumers often fail to act, or make simple short-cut decisions, which is often the decision to not buy insurance at all.


The economics of private insurance solutions

The lack of understanding is not helped by the availability of a wide and sometimes conflicting range of estimates of the need for LTC. For example, one US study predicts that “at least 70% of baby boomers are expected to need some LTC service at some point, and that 40% are projected to require nursing home care.”53 Another report, however, says “among people age 65 or over, only 14% need long-term care,” rising to half after age 85.54 In Europe, a comparative projection is that in the Netherlands, there is a 20% probability of males incurring costs for nursing home care over their lifetime.55 In many emerging markets, meanwhile, there are no estimates at all. Such variety of benchmark reference points can be very confusing for a person considering his/her future LTC needs.

Even if people are aware of the risks, many mistakenly believe a government or some sort of public LTC scheme is available, which takes away any incentive to make private provisions. This is the case in the many advanced markets which do have public or social security provisions of some sort. However, these provisions may not be universal LTC schemes and the benefits far from comprehensive. It may even be that individuals speculate that once the baby boomers start needing care, public schemes will be introduced (a negative social norm). This perception crowds out individual responsibility around the need to arrange for private LTC.

In a Swiss Re survey of more than 15,000 consumers in 14 European countries, close to 70% said the government is responsible for the provision and funding of LTC.56 This perception was most widespread in the Nordic countries with universal tax-based LTC systems. In countries where LTC is means-tested, financed out-of-pocket or by insurance, the responsibility was seen to lie more with the individual than the government. Nevertheless, in all but one country, at least half of survey respondents put the onus for “nursing care for the very old” on the government (see Figure 6). Interestingly, in all countries, consumers expect the role of the governments to decline over time.

Misperceptions regarding what social security and governments will provide in terms of LTC are evident in North America also. In the US, 86% of the baby boomers under the age of 65 do not know if Medicare covers LTC, or they overestimate the coverage. This lack of awareness is prevalent even though middle-income US citizens with Medicare (ie, those 65 and over) cite long-term care in a facility and long-term care at home as the top healthcare expense that they feel will threaten their financial security in retirement.57 In Canada, many mistakenly believe that all of their long-term care needs will be met by governments. In reality, however, they will largely be responsible for the cost of their own care needs.58

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58 Canadian Life and Health Insurance Association, (2012), op. cit.
The expectation that children will take care of their parents further crowds out private responsibility for LTC insurance. In many emerging markets, traditionally one of the children or a child-in-law takes the role of the caregiver. However, the transition towards smaller families, increasing labour force participation by women and higher mobility of the workforce (increasing distance to the dependant) challenge these traditional arrangements and brings their sustainability into question.

For many consumers, LTC insurance is deemed too expensive or even unaffordable. Thus, the development of the market may be hindered because low- and middle-income groups cannot afford the coverage, while high income groups do not need it. Nevertheless, given the generally limited median incomes of the elderly and low accumulated assets, the cost of the actual services of LTC is even more unaffordable for most people than LTC insurance.\(^5\) In the US, around 27% of consumers among the wealthiest 20% had a LTC policy in 2008 while among the poorest 20%, only about 4% owned LTC insurance.\(^6\) Affordability is related to the age at which a policy is bought. If individuals purchase LTC insurance at a young age, the premiums are much lower. According to one study, an individual buying LTC insurance at age 60 will pay almost double the annual premium rate an individual buying the same coverage at age 45 does.\(^7\) At younger ages though, incomes are lower and there are many competing and more immediate spending needs (raising a family, buying a car or house, etc). End-of-life issues far in the future do not feature prominently in peoples’ thinking. The upshot is that many only start to think about their LTC needs when they approach retirement age, when the risk is already relatively close and the premiums, therefore, high.

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\(^5\) F. Colombo et al. (2011), op. cit.

\(^6\) J. R. Brown et al. (2011), op. cit.

\(^7\) See Herleitung der Rechnungsgrundlagen DAV 2008 P für die Pflegerenten(zusatz)versicherung, German Actuary Society.
The economics of private insurance solutions

Affordability is a severe issue for the elderly. In Germany, in 2012 those between 50 and 65 had a median income of EUR 20,688.62. For a 65-year-old man, an LTC premium would have taken up 7% of his income and for a woman of the same age, 11%. By comparison at age 45, the LTC premium would have taken 3% and 4.3%, respectively, of the male and female median income. In the US, the premiums similarly get more expensive with age (see Figure 7). Further, as there is no mandatory basic LTC insurance in the US (in contrast to Germany), the benefits of private cover and hence premium payments are typically much higher, and therefore more unaffordable, particularly for the elderly.

Behavioural economics and cognitive biases such as procrastination, ... Finally, behavioural economics and cognitive biases play an important role in consumer thinking around buying insurance.63 People often postpone making tough decisions about the future because they can involve unpleasant discussions and/or thoughts. Procrastination is very much part of the decision-making process when it comes to buying LTC insurance. Procrastination and affordability are interrelated: with every year of postponement, premiums become more expensive and potentially unaffordable.

... overconfidence and loss aversion also play a role in limiting the uptake of LTC insurance. Another well-established bias is overconfidence. Many people think ‘good’ things are more likely to happen to them than to others and ‘bad’ events – such as becoming dependent – less likely than to others. Loss aversion is also important: paying for decades into a policy with the risk (actually rather the luck) of not receiving anything back is a big hurdle for consumers to cross when it comes to making a decision about buying LTC insurance.

62 Source EUROSTAT.
63 For a discussion of how behavioural economics impacts insurance buying see sigma 6/2013 Life insurance: focusing on the consumer, Swiss Re, (2013).
“You’ll never walk alone” – a multi-stakeholder approach

The challenge of providing care for the ageing population requires a comprehensive solution, including all stakeholders: insurers, governments, healthcare institutions, current and potential care providers, and current and future potential consumers of care. Starting from different points, most countries will have to reform their systems to find sustainable solutions for growing care demands. This chapter looks at possible policy and other responses.

As a starting point, governments could help raise consumer awareness of the risks and costs of care solutions by clearly communicating what care is provided by the state. This would help individuals make more informed decisions about how best to provide for their old-age care needs. It would also give insurers a better-defined backdrop from which to develop care products.

Governments could partner with insurance companies as potential investors in care facilities. At present, governments often house patients inappropriately and very expensively in hospitals, and do not have the financial capacity to invest in care infrastructure. By partnering with insurers, governments would benefit from lower costs and funding needs. For insurers, care infrastructure could be an interesting asset class because their returns are positively related to the development of care needs. Therefore, care infrastructure would be a good asset match for care risks on insurers’ liability side.

Policymakers also need to be mindful of regulations which may hinder the development of a private market. For example, excessive capital requirements on very long-term products can create impediments to insurers’ willingness to participate in the market, and also make products more expensive.

Another approach would be to work with employers to institute programs similar to voluntary pensions, such as the 401(k) in the US. Employer involvement can also help raise awareness of LTC risks. Group LTC insurance does exist in certain markets such as the US and France, but employers typically do not contribute towards the cost of premiums. With the right design (for example opt out instead of opt in) and tax or other financial incentives, it may be possible to make some people start paying for policies early when it is still affordable, as in Singapore. It is along these lines that the Taiwanese government is expected to launch a LTC insurance system in 2016, financed collectively by the state, private employers and the insured. Similarly, in the UK there is discussion about a ring-fenced pension system dedicated to care solutions and with additional tax incentives. The idea is that this “Care Pension Fund” is to be used only to fund care expenses. Further, if the fund is not used, it can be passed on to family descendants without inheritance tax.

The care solutions challenge is also about social behaviour. Many people have the mind-set that retirement begins at a certain age, say 60 or 65, with no flexibility. They also expect that any available government programs in retirement will also begin at this age and cover their care needs. These attitudes could be encouraged to shift towards the possibility of working longer through incentives and labour market flexibility and by removing any structural and legal barriers or other disincentives to working longer. The work could be on a full- or part-time basis and would give individuals more time to save for future care needs.

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64 P. Hope et al., (2012), op. cit.
An integrated approach

There needs to be stronger coordination across the different agents involved in the delivery of care services and solutions. Currently the financing and delivery of care is highly fragmented, and in most cases it is separate from healthcare provision. Moreover, there is often no coordination between social services and home-care providers, which generates extra costs and inefficiencies, and does not deliver the best outcome to the patient.67 An example of a well-coordinated system is “LifeChoices” in Michigan. This is a membership program with an upfront fee (USD 30,000–50,000) and a monthly fee (about USD 400) to cover all core services and assists people to age at home.68

Managed long-term care, which coordinates the provision of care across various services from health to social care and across the multiple dimensions of care from informal to formal, is another example. In the US, demonstration programs that coordinate all care in this manner have been established. In exchange for a lump sum per person paid by the government,69 the health plan agrees to provide all aspects of care services for persons in the program. Discussions to set up similar programs have occurred in Asia but no plan is actually in place yet. In the UK, the “Better Care Fund” is an analogous idea.

In the future, employers who provide health insurance through the group market could perhaps include managed care coverage as part of the employee benefits package. But it will be some years before this can happen as there are still many unanswered questions about the cost-effectiveness of the managed care program. Also, the market would need a rule to deal with employees who switch jobs and/or retire.

Home is where the heart is ... and where care could be?

Many people want to stay at home when they need care.70 And, given the large cost differentials between hospitals, long-term care facilities and home care, significant savings can be achieved by implementing structural changes that help them do so. Existing insurance products often include home-care coverage. Even so, in many cases a reliance on medical models of care and a lack of community-based support services has led to “the continued inappropriate placement of older people to residential care facilities.”71 For example before reforms in 2000, in Japan the elderly were admitted to hospitals because there were no nursing homes (so-called “social admissions”). The reforms were implemented specifically to cut the number of inappropriate long-term admissions into general hospitals.72

Care provided by family members is an integral part of the current care delivery system, and will remain so if the aim is to keep people at home for longer. However, demographic and societal trends are putting pressure on family-provided care and the availability of family care will not keep up with the increasing care needs of the elderly. One option to incentivise more family care could be to offer state payments for care services, although this is difficult when government budgets are already stretched. In some countries, dependants living at home can choose a cash benefit in lieu of receiving care in an institutional setting to pay informal caregivers.

67 America’s Long-Term Care Crisis, Bipartisan Policy Center (2014).
69 The demonstration programs are initially undertaken for a portion of the “dual eligibles” who qualify for means-tested public LTC under Medicaid and are also old enough to qualify for public healthcare under Medicare.
The aim is to keep people at home and contain overall care services costs. In the Netherlands and Germany, these cash benefits are very popular, even though their value is lower than the equivalent services in-kind.\textsuperscript{73}

Families could also be a target market for care solutions. Such solutions could range from traditional LTC insurance, to a product that covers some parts of the care provided by the family member to alleviate the burden on that caregiver and also give him/her an opportunity to continue to work. And, as in many countries already today, care solutions could include respite care riders, giving a caregiver a chance to go on holiday while a nurse takes care of the family member at home.

With the demographic shifts taking place in many parts of the world, the issue is also about finding and training people to care for the elderly. One solution could be to have the “young old” (people just retired) take care of the “old olds,” an idea that challenges traditional models of retirement. Likewise, initiatives to engage younger retirees in the community, for instance re-employment in urban gardens, community nurseries and in community restaurants, can reduce the burden on pay-as-you-go systems. Such ideas have been piloted in Japan and have increased the community workforce and helped contain medical and nursing cost. Importantly, they also help the elderly feel less socially isolated and maintain their physical and mental functions.

In some countries such as Austria, Germany, Switzerland and Italy, but also in many Asian markets, migrant workers are significant providers of informal care. Often these carers operate in a “grey” market. For instance, in Italy less than half the 2 million-plus home care assistants are formally employed.\textsuperscript{74} In implementing changes to better integrate the informal and formal care sectors, lawmakers may need to consider migrant worker rights. Additionally, issues arising in the home countries from the outflow of potential carers need to be addressed. In some cases, going abroad may be an option for the elderly themselves: seeking less expensive care in a market with good care infrastructure.

**An ounce of prevention**

Health prevention initiatives can generate significant cost savings.\textsuperscript{75} Lifestyle-related chronic diseases such as coronary artery disease, stroke, diabetes and some cancers are a growing burden on individuals and national health systems. Yet many of the major risk factors leading to ADL limitations … are preventable.

Obesity and smoking, for example, are key contributors to chronic disease trends. In the US, estimates attribute 12% of type 2 diabetes and 22% of coronary heart disease, as well as other conditions, to lack of physical activity.\textsuperscript{76} Meanwhile, several studies have concluded that improved diets and increased levels of physical activity reduce the risk of chronic conditions and associated disability, and that appropriate management of the conditions can limit or reverse ADL limitations.\textsuperscript{77} A study in France found that intellectual and physical activity could even help hold back mental deterioration. Specifically, the report cites a 15% reduction in Alzheimer’s detection in workers who retired at age 65 over those who retired at age 60.\textsuperscript{78}

\textsuperscript{73} These schemes raise the issues of moral hazard and fraud, but this is true for all government social programs and insurance products.

\textsuperscript{74} R. Tarricone et al. (2008), op. cit.


\textsuperscript{76} R. Nugent, “Chronic Diseases in Developing Countries”, Center for Global Development, (2008).


\textsuperscript{78} C. Courbage, Editorial to the Geneva Association Health and Ageing Newsletter no 29, (2013).
Creating a better care market for older lives

A portion of future (expensive) care needs can be avoided by smaller, but earlier investments in preventative measures. Insurers and other care services funding providers may be able to benefit from initiatives that keep people well and active, rather than just focus on extreme acute care. To incentivise people who, for instance, do not want to stop smoking, premiums could be differentiated accordingly, and there could be other rewards for those who do take preventive actions. Such rewards programs have already been introduced by L&H insurers in South Africa, who use telematics and other types of data collection to monitor the insureds’ actions.79

Several countries have made a start with healthy ageing initiatives. For example, Taiwan’s “Healthy People 2020” is a health-promotion program for older people with a focus on the prevention and management of chronic conditions including diabetes, hypertension and asthma. In Japan, the government has mandated wellness programs. In Singapore, initiatives include regular health screenings for early detection of illness, and a focus on social integration of seniors and inter-generational cohesion. Such undertakings can all be part of care services and solutions.

Service innovation through technology

Just as health insurers have realized the value of subsidising gym memberships, care solutions insurers and public payers for care services may benefit from subsidies that encourage the application of technologies and devices that help older people live alone longer.80 Or, insurers could provide the distribution channels for these types of technologies.81

Technological innovation can enable better health monitoring, care coordination and a longer period of living unassisted/alone. For example remote monitoring devices can track glucose levels in diabetics, detect falls and in more advanced cases, even be linked to analytical systems that predict impending heart failure.82 Similarly, medication adherence can be tracked by smart pill bottles that notify a caregiver via text message of cases of non-compliance.83 Locator devices can assist with the management of dementia patients.84 And various tele-health initiatives can reduce admissions to hospitals, number of home visits and visits to general practitioners.85 These and other remote interventions can be less expensive than constant monitoring in a nursing facility, and increase quality of life by helping people stay at home.

There are also new devices that help caregivers coordinate overall care needs. An example is an online tool called Grouple, which is being piloted in the UK for carers of the elderly with dementia. The platform’s aim is to establish harmonised routines and patterns of care among multiple family caregivers, and to provide access to an online network of peers to share concerns and experiences.86

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79 See for example Discovery Vitality: http://www.hr.uct.ac.za/ust/hr/remuneration/healthcare/vitality_2014.pdf (accessed 1 September 2014).
80 Australian Academy of Technological Sciences and Engineering, (2010), op. cit.
83 Medication non-adherence accounts for more than 10% of older adults’ hospital admissions, nearly 25% of their nursing-home admissions, and 20% of preventable adverse drug events in the community setting. Technologies to Help Older Adults Maintain Independence: Advancing Technology Adoption, Center for Technology and Aging (2009), and Statistics you need to know: statistics on medication, American Heart Association, (2009).
85 Australian Academy of Technological Sciences and Engineering, (2010), op. cit.
86 P. Hope et al., (2012), op. cit.
To prolong a person’s independence, home modifications may be necessary. This includes non-medical equipment such as special chairs, hoists, rails, ramps into the house, adapted toilets, showers and baths, lifting equipment and more.87 Paying for such equipment and modifications rather than for nursing home care may be more cost-efficient and also improve quality of life.

A step up from basic modifications is the concept of smart homes, which in the future can enable the elderly to live independently longer.88

Some insurers and developers have built entire care-continuum-friendly “retirement cities.”

Purpose-built “retirement cities” consisting of independent- and assisted-living apartments, a nursing home-type facility and a hospital are gaining popularity. Sometimes, this concept is referred to as a Continuing Care Retirement Community. In Florida, a retirement village in this vein with golf courses and social amenities for retirees alongside healthcare facilities is the fastest growing metropolitan area in the US.30 In similar residential developments in China financed by China Life and Ping An Life,91 apartments are “fitted with remote sensing equipment to monitor the vital signs of high-risk residents.” Other countries have retirement developments of this nature also.

Innovative private insurance care solutions for older lives

Insurance alone cannot solve all care service and solution issues, but it can help diversify the risks and make care more efficient. However, to meet the growing demand and the same needs as classic LTC products, but in a more tangible and easily sold way, a fundamental re-think of the design and purpose of current care insurance products is required.92

Annuity products

Immediate-needs annuities (INAs) have been introduced in some markets. This single-premium product is bought at the point when a dependant has to move into a nursing home, so the benefit is very tangible compared to a traditional deferred LTC policy. The issuer of the policy agrees to pay the costs of the stay, no matter how long the dependant will require institutional care.

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87 R. Tarricone et al. (2008), op. cit.
88 Australian Academy of Technological Sciences and Engineering, (2010), op. cit.
92 Traditional comprehensive LTC insurance products are not well suited for everyone, but in countries where there is no public provision, or only “lender of last resort”-type cover for low-income individuals, comprehensive LTC insurance may be a good way of dealing with LTC risks for those who can afford it.
Creating a better care market for older lives

The value proposition of INAs to the consumer is that it eliminates the risk of paying for an extended and sometimes unaffordable stay in the nursing home. As mentioned earlier, a BUPA study in the UK revealed that the average length of stay in a care facility is 2.2 years, but 25% of the patients stay 3.6 years or longer, and 10% stay for more than six years (see Figure 8). Thus, buying at the point of need provides value to the consumer: he/she may have enough accumulated assets to be able to afford a year or two of institutional care, and the immediate needs policy removes the risk of running out of assets while there is still need for care.

A disadvantage of INAs is that the policies are expensive (though cheaper than an extended nursing home stay). In a competitive market the premium needs to cover the average costs of the nursing home stay for the duration of stay plus the costs of providing insurance.

A significantly less expensive option is the deferred immediate-needs annuity (also known as a deferred care plan). This is bought at the time of admission to a nursing home, but pays care costs only after a waiting period such as two years, thereby eliminating the tail risk of the costs. The waiting period is like a deductible and the price, therefore, only a fraction of a deferred LTC or an INA because only the few dependants staying longer than the average in these care settings receive benefits.

Hybrid products

Hybrid products combine LTC insurance with life, retirement/pension or critical illness products. They pay out the death benefit early, or increase the monthly payment from the annuity at the onset of the LTC need. Their advantage over traditional LTC products for the consumer is that if care is not needed, the underlying life or retirement product still gives the insured a payout. This can help overcome the loss aversion and the mental accounting challenges traditional LTC insurance faces.

Figure 8:
Survival rates of residents in a nursing home, the UK, November 2008 – May 2010

The tail risk of care needs can also be addressed with deferred immediate-needs annuities.

Hybrid products may be easier to sell because they provide a payout to the insured whether or not a need for LTC arises.

From the insurers’ perspective, hybrid products have a lower risk profile than stand-alone LTC insurance, as some risks diversify. In particular, the sensitivity to changes in assumptions (about investment income, lapses mortality and incidence rates) is materially lower for hybrid products. This reduces the costs and hence the price of these products. The LTC feature can also be a rider on a traditional life/annuity product, rather than a full combination product. For example, in Hong Kong a global life insurer offers a rider to a term annuity that pays an extended income for life if the policyholder becomes unable to perform certain specified activities of daily life.

Services and financing

Assisted living insurance (also known as short-term care insurance) is intended to help support a policyholder and his/her family in the initial stages of dependency. It provides financial support for a set period and advice in cases of unexpected care costs, allowing the individual and family some time to organize financing for future care costs. The insurance also provides access to a suite of services from care, assistance, financial advice, to offering solutions and taking over arrangements as needed.

Other insurance approaches

In some cases, it may be better to address specific aspects of the care need rather than the entire range of care solutions in one product. This would make the insurance products more affordable and less complex for consumers. For example in South Korea, targeted products in senior health and cancer care have met with some success. Dementia and arthritis have been some of the other targeted conditions, with success largely due to appropriate distribution, low price and simple and understandable lump-sum benefits. This could be replicated in other markets by finding niche needs and addressing them from the ground up as opposed to analysing and trying to address the total need at once. However, this is very country-specific because of cultural reasons and the different public schemes in place.

Re-labelling existing LTC insurance products in more positive terms could also help. The current LTC insurance products focus on compensation for loss of independence, and in particular ADL failures, which for many consumers seems like a horrendous personal state to experience. This is an additional psychological reason not to buy. Products which extend independence may have a much more positive marketing message and be purchased more readily than current LTC products. Marketing with wording reference to lifestyle maintenance or independence assistance, for example, may lead to higher sales of LTC insurance.

Non-insurance solutions

Some of the elderly, at least in the advanced markets, are asset rich but cash poor. Products to monetize illiquid assets can provide relief and may complement the suite of existing solutions to finance care. Reverse mortgages, known in some markets as “equity release” products, allow mortgage-free homeowners access to the equity in their house. The homeowner can either sell the house at a discount and be allowed to stay there for life (sale model). Or he/she can get a lump-sum payment, periodic payments for life, access to a line of credit, or any combination of these options (loan model). During the life of the loan, the homeowner makes no interest or principal payments, and accrued interest is added to the principal. The loan falls due only when the borrower and their partner both die or permanently move. At that time, the house is sold and the proceeds used to repay the mortgage and interest. Any additional funds go to the borrower or their estate.

94 See Quantification of the Natural Hedge Characteristics Long-term Care – Combination Life or Annuity Products Linked to Long-term Care Insurance, SOA, (2012).
Creating a better care market for older lives

The market for reverse mortgages is well developed in the US and UK. The estimate for continental Europe is that EUR 20 billion could be released from home equity in the next 10 years. In China, with an eye on the ageing challenges ahead, a pilot plan for reverse mortgages has been launched. Insurers could be natural suppliers of reverse mortgages given the long-term nature of their business and the link to life risks. However, there are many challenges as it is difficult to manage and hedge the risk related to the properties, which are often run-down and not well-maintained. Similarly, consumers may be wary of them because they are difficult to understand, and they preclude the elderly from leaving a legacy. The availability of reverse mortgage solutions also depends on legal and regulatory aspects. For example, under Solvency II, it’s not clear how reverse mortgages can be used to back life insurance liabilities.

Demographic trends will result in an increase of elderly persons with long-term care (LTC) requirements. The needs of the aging population and how these will evolve is a complex question that is not yet fully understood. Indeed, the financing and provision of effective care solutions for the elderly will be one of the most challenging issues facing society in the coming years.

Today’s means of funding and providing care services are not sustainable. Both societies and individuals are generally unprepared for the LTC challenge. To cope with the coming silver tsunami, a multi-stakeholder approach is required. From the outset, more focus on health management at older ages will help people remain independent and living at home for as long as possible. This will help to save costs and increase the quality of life for all.

Insurance is not a silver bullet to the care conundrum and cannot in isolation solve the challenges ahead. However, insurance can help make the use of scarce funds more efficient through risk diversification.

Private voluntary LTC insurance has not been a runaway success and to become an integral part of the care solutions package, insurance products need fundamental re-think. Traditional LTC products have proven unappealing to both buy and sell. There is a great deal of scope for product innovation and improved design to overcome the perceived weaknesses of traditional LTC insurance products. In particular, re-designed products should present a more visible and tangible value proposition that is at once both more appealing and affordable for many people.

For example, immediate-needs annuities are bought when severe dependency sets in and they reduce the tail risk of LTC needs. Hybrid products offer a payoff even if the insured does not become dependent. Short-term care provides professional support and services at the initial stages of dependency. In some markets, targeted products that address specific aspects of the care need rather than the full range of care solutions have provided significant support for the elderly.

Last but not least, consumer awareness about LTC needs, their risks and costs must be raised. In line with this, governments must better communicate the public funding and services available, and what is the realm of individual responsibility. This will help foster consumer engagement with and preparation for individuals’ own old-aged care requirements.
## Appendix: LTC solutions in select countries

### Insights on private LTC insurance from specific markets.

In this appendix, seven markets for private LTC insurance are discussed, along with a brief description of the public LTC sector which defines the operating environment. The selection is based on the size of the private LTC insurance market, but also with regards to any policy and business insights that can be drawn from the examples.

### The US – private LTC insurance is the main mechanism for risk sharing

The largest private LTC insurance market is the US. LTC insurance policies were very popular in the 1990s and premium volume grew from about USD 2 billion in 1995 to USD 11.5 billion in 2012. Around 80% of these premiums were for individual business, and the rest sold as group business. In recent years, however, business growth has been weak and often driven by rate increases rather than new sales.  

98 Source: LIMRA.

#### The typical LTC insurance policy in the US offers reimbursement of LTC costs.

The typical insurance solution offers reimbursement of LTC costs to a daily cap. The vast majority of policies provide comprehensive coverage, which pays for both home care and care in nursing facilities. Often there is a limited benefit period, but lifetime contracts are (were) also available. Most contracts have a waiting period of around three months before the insurer starts to pay care costs that acts as a deductible.

99 Various options that enhance coverage for LTC insurance have been sold. Typically policies offer a benefit that escalates over time at a pre-determined fixed rate, eg 5%, to compensate for inflation. Some policies offer a “non-forfeiture” option which, for a higher premium, provides some benefits in the case that the policyholder stops paying the premiums. Other services offered by some policies include hospice care, respite care, care after a hospital stay, or caregiver training for family members.

### Germany – mandatory LTC and supplementary private LTC insurance

In Germany compulsory universal LTC insurance was introduced in 1995. There are two parallel mandatory schemes: social LTC insurance for those with social health insurance and private LTC insurance for those with private health insurance. The social LTC insurance is pay-as-you-go-financed through payroll contributions. Private LTC insurance is pre-funded through premium payments (see left panel of Figure 9).

### LTC insurance is the “problem child” in the US L&H industry.

Despite its size, the US is not the showcase for private LTC insurance. Life insurers have suffered heavy losses and were forced to increase rates on large blocks of policies, which upset many policyholders and resulted in a loss of reputation of the industry. Moreover, many insurers have exited the market.

### Among other things, assumptions made at the time of pricing have proved to be too optimistic.

The main issues confronting the US LTC insurance market were lower-than-expected lapse rates, low investment returns, high capital requirements, underwriting challenges, and problems with distribution networks (high commissions).

### New hybrid life products have been sold successfully in the past five years.

However, the Pension Protection Act of 2006 improved the tax treatment of LTC insurance and allowed for the development of hybrid products. These new products, mainly life insurance with acceleration riders, where the death benefit from the life insurance can be withdrawn for LTC or chronic illness needs, have been introduced and sold successfully in the past five years. Specifically, premiums for hybrid products grew strongly between 2009 and 2013 (CAGR 34%) and new business for 2013 reached USD 2.6 billion.

### Germany has been compulsory since 1995.

Benefit eligibility criteria and payments are equivalent for both systems. Benefits comprise daily allowances for informal care, formal care at home and in nursing homes. The amount paid for each of the three benefit types is explicitly defined and graded depending on the level of dependency.
It is well understood that benefits from the mandatory systems do not cover the full costs of long-term care. The mandatory LTC insurance is estimated to pay about 43% of the total nursing home costs for light dependency and 47% for heavy dependency. In absolute terms, the annual protection gap per person is thus USD 20 700 for light and 26 000 for heavy dependency, respectively. Supplementary LTC insurance to cover the gap is available from both life and health insurers. Health insurers offer supplementary LTC insurance with full or partial cost reimbursement on top of what is covered by the mandatory plan and daily allowances. Life insurers offer long-term care annuities which pay a fixed amount depending on level of dependency. Life insurers also offer stand-alone LTC products and LTC riders to a life policy.

Between 2002 and 2012, voluntary LTC insurance in Germany grew by 20% annually to about EUR 852 million (USD 1 090 million, see right panel of Figure 9). This growth was fueled by an omnipresent debate about the sustainability of the mandatory social LTC insurance mechanism, the protection gap and how to incentivize consumers to privately provide for their LTC needs.

To increase the uptake of supplementary LTC insurance and close the protection gap, a program called Pflege-Bahr, named after the health minister Daniel Bahr, was introduced in 2013. Those who purchase Pflege-Bahr with premiums of at least EUR 10 per month receive a EUR 5 government subsidy. In the first year of the program, two thirds of the 500,000 new supplementary LTC policies purchased were Pflege-Bahr contracts.

Figure 9:
LTC contributions and premium income, in EUR million, for mandatory LTC insurance (left panel) and voluntary/supplementary LTC insurance (right panel) in Germany

Source: Bundesministerium für Gesundheit (German Federal Ministry of Health), Steria Mumment, based on Bafin.
### France – social health insurance, government and private LTC solutions

In France, financial support for LTC at home or in an institution is mainly provided for by the universal public health insurance system and personalized allowances for autonomy (APA). APA is intended for people aged 60 and above to help pay for expenses linked with loss of independence. The level of benefit is a function of an individual’s degree of independence. However, APA is also means tested and depending on one’s income, benefits can be reduced by up to 90%.

For formal home-care, APA provides support towards any expenses incurred in line with a personalized care plan identified by a social-medical team. In 2010, benefits varied from EUR 1,235 per month for the most severe cases to EUR 530 for low dependency levels. Neither level of benefits is sufficient to cover the full estimated costs of home-care of EUR 1,500 to 4,000 per month.

The costs of staying in a nursing home were estimated at EUR 34,705 in 2012, with three components: (1) the health cost of EUR 11,844, which is borne by social health insurance; (2) the accommodation cost of EUR 11,616, which is paid fully by the dependant; and (3) the care cost (ie, non-medical care needs such as feeding, help with dressing etc.) of EUR 11,844, for which APA makes means-tested contributions, with any remaining portion borne by the dependant and his/her family. It is estimated that families spent at least EUR 6 billion in 2007 for accommodation and dependency fees (total LTC expenditures were estimated to be EUR 34 billion in 2007, or 1.8% of GDP).

Life insurers provide supplementary LTC insurance to reduce the remaining gap. Premium income was EUR 466 million in 2012 with 1.8 million insured (of which 75% were individual contracts). So called Mutuals 45 and Institutions de Prévoyance also offer LTC insurance, and generated premium income of EUR 138 million and EUR 25 million, respectively, in 2011, from 3.6 million and 0.3 million insured. The vast majority of the contracts are written on a group basis. In France, more than 16% of the population over 40 years of age has private LTC insurance (2012), compared with about 5% in the US.

The contracts provided by French life insurers are defined benefit. In other words, once the policyholder is eligible, a regular fixed amount of money is paid for life (although there are also lump-sum policies and contracts with limited payment period). For contracts covering light and severe dependency, benefits averaging EUR 371 per month were paid in 2012. For contracts only covering severe dependency, benefits were EUR 574 on average.

### Japan – social LTC insurance crowds out private solutions

In 2000, Japan created a public LTC insurance system funded by a combination of premiums and taxes that finances approved in-kind services. The scheme covers the population aged 65 and above as well as age-related illnesses for those aged 40–64. Benefits are only provided in the form of services (in kind), with no possibility of receiving a cash benefit. The fact that cash benefits are not offered was a specific design feature to avoid the burden of care falling on (unpaid) female family members (sometimes referred to in Japan as “daughter-in-law syndrome”).

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103 Those who cannot afford it may be eligible to public social assistance for housing (l’aide sociale à l’hébergement).
105 Different social insurance agencies also provide benefits. For instance, retirement insurance proposes benefits in kind such as home assistance for people whose dependency level is not severe enough to receive APA.
107 FFSA GEMA, (2013), op. cit.
The LTC system operates on social insurance principles, with benefits provided irrespective of income or family situation. The overall cost of the LTC insurance system doubled between 2000 and 2006 because the new system gave more opportunities for elderly persons to use formal LTC services. The government has projected that the cost of LTC services will rise even further, from 1.6% of GDP in 2010–11 to 3.3% by 2024–25. As the burden increases, the government may need to increase co-payments, introduce means-testing or reduce access to some services.

Private LTC policies are available either as principal coverage or as a rider to life and/or medical insurance policies. Typically they allow the insured to receive cash benefits after reaching a certain level of dependency (paid as a lump sum, an annuity, or a combination of the two). However, with the introduction of the universal (and very generous) public LTC insurance system, private LTC insurance volumes have suffered a setback.108

Israel – high risk awareness helped develop a LTC market

In Israel, the Long-term Care Insurance Program (LTCP, a publicly-funded LTC scheme) provides services and benefits designed to supplement informal care provided by family and friends, and encourages elderly people to remain in their communities as long as possible. Individuals must be citizens or permanent residents of Israel and be above the retirement age of 67 (for men) or 62 (for women).

Eligibility for services from the program is means-tested. However, the means test is sufficiently high so that only the very wealthy are excluded. The LTCP services cover about 80% of the elderly population, at a cost of approximately USD 1 billion in 2011 or 0.5% of Israel’s GDP.

Awareness of LTC risk is widespread and Israel is one of the biggest private LTC insurance markets. Claimants receive compensation for the cost of care in a nursing home or care provided at home up to a specified amount. Benefits are ADL-triggered and tiered. Premium income grew from USD 118 million in 2003 to USD 710 million in 2012, making LTC insurance the fastest growing L&H line of business. Two thirds is written on a group basis, typically sold through affinity groups and employers.109

Singapore – a public-private partnership

Singapore has a mandatory national medical savings scheme called Medisave, which helps individuals put aside part of their monthly income into individual Medisave accounts to meet their own or their family’s healthcare expenses. LTC costs are financed through a mix of government subsidies and disability insurance (ElderShield), the premiums of which can be paid for from individual’s Medisave accounts. In addition, families unable to afford remaining LTC costs even with subsidies and insurance can receive further assistance from Medifund, a safety net for needy Singaporeans.

The ElderShield program was launched in 2002. It is a public-private partnership designed by the government but priced, sold and managed by private insurers. ElderShield provides automatic enrolment for individuals at the age of 40. However, individuals can opt out of the plan within the first three months. By 2013, premium income amounted to about USD 160 million/SGD 199 million. The number of ElderShield policies increased from 0.75 million in 2008 to 1.1 million in 2013, an increase of 5.2% per annum.110

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109 This includes Government subsidies for various LTC services, as well as Government schemes like the Foreign Domestic Worker Grant and Senior’s Mobility and Enabling Fund (SMF).

110 Singapore Ministry of Health.
Appendix: LTC solutions in select countries

The popularity of the program has been aided by the ease of paying the ElderShield premiums, which are deducted automatically from an individual’s Medisave account, and the relatively cheap premiums. However, there is a debate around whether this engenders a false sense of security, as the benefits are roughly enough to pay the cost of a home helper (who may have minimal training in eldercare).

ElderShield benefits are up to SGD 400 per month, for up to six years.111 Depending on the degree of dependency and the quality of the accommodation, nursing home charges range from about SGD 1 000 to SGD 3 500 per month.112 ElderShield policyholders wanting additional insurance to reduce the existing protection gap can also purchase an ElderShield Supplement with higher benefits. The premiums for ElderShield supplements can also be paid for from an individual’s Medisave account.

The UK – almost no public LTC funding

In the UK, the National Health Service (NHS)113 provides universal healthcare. LTC, however, is not included and the bulk of the old-aged care costs must be borne by the dependant and their families.

For LTC benefits, there is a means-tested safety net requiring individuals to significantly spend down their assets (including property if not occupied by the dependant or spouse). Only once assets are below a certain threshold is the person eligible for state support.114 As a consequence, the dependant is often forced to sell their home or liquidate any available assets to fund nursing or residential home care.

The LTC protection gap in the UK is significant. Private LTC insurance has been sold since the early 1990s, but the market has grown slowly and there are only a few players, mainly offering immediate-needs annuities (INAs). The traditional product – pre-funded LTC insurance with ADL and cognitive impairment triggers – has not been popular, and the last provider to offer pre-funded LTC insurance exited the market in 2010. LTC bonds are similar to pre-funded care plans but allow inheritance of unused capital. Even so, UK consumers have likewise not been big buyers of LTC bonds.

The most promising products in the UK insurance market are INAs. These are purchased with a single premium when an individual is already in need of care. INAs have been relatively successful, aided by certain tax efficiencies,115 although premium income was only about GBP 130 million in 2012.

Given the tough eligibility requirements for state support, it is surprising that LTC insurance penetration in the UK is so low. Either the products on offer do not meet consumers’ needs, or many people are simply not aware of the LTC risks they face.

111 Plans that went in-force before end of September 2007 offered a benefit of SGD 300 for up to five years.
113 There are four distinct NHS, one each for England, Scotland, Wales, and Northern Ireland.
114 The threshold for eligibility is GBP 23 250 in England and Wales, and GBP 24 750 in Scotland.
115 If pension savings are used to fund LTC nursing care costs and paid directly to the care provider via an immediate needs annuity, the proceeds from the pension are tax free, whereas taking the pension as cash income benefits (whether or not the money is then paid to a caregiver) would attract income taxes.
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