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Caring for the Frail Elderly: A U.K. Perspective

by David Gulland

Author's Note: (this article summarises a talk given at the SOA meeting in Dallas. Please contact the author at dgulland@bw-deloitte.com *if you would like to receive a full copy of the slides used at the meeting)*

This article intends to give a short overview of the situation in the United Kingdom ("U.K.") highlighting those areas that should be of particular interest to readers in the USA. There are three parts to this article:

1. An overview of the demographics and method of supply of LTC
2. A review of the ongoing debate on the role of public funding, and
3. A summary of the insurance industry's response

In brief, the latter makes depressing reading since insurers have failed to turn a clear consumer "need" into a "want," with sales of business being significantly below what could be achieved. This may provide an opportunity for U.S. companies with successful marketing, distribution, underwriting and claims management skills to export successfully to the U.K. market.

Demographics and Supply of LTC services

The U.K. population is expected to age in line with many similar Western economies, as summarized in the following table. (Slide 1 of attached Powerpoint). The key figures here are the growth in the over 85s, expected to treble over the next fifty years. The effect of this is exacerbated by the falling birth-rate and reduction in size of the working population. Unlike the USA, immigration does not materially effect these demographic projections.

There are various studies into the prevalence of the need for LTC amongst the elderly, but no single source can truly be regarded as reliable. Various studies are discussed and quoted in the Report of the Royal Commission into Long Term Care set up in 1997 and which reported in early 1999. A "benchmark" set of data is as follows: (Table 2).

To address this paucity of reliable data a new body was set up during 2001 called the English Longitudinal Study into Aging. This has some similarities to the National Long Term Care Survey in the USA.

As is common across most countries there is an increased effort to use home care rather than moving individuals into institutional care. Nonetheless institutional care is still the most significant part of the LTC market (as measured by costs) as indicated by the following table (Table 3). What has changed over recent years is the nature of the ownership of the LTC providers. For example public-sector institutional beds have fallen from approximately 40% in 1990 to approximately 17% by 2000. Similarly the supply of home health from the public sector has fallen from almost 100% of hours provided to approximately 50% over the same period.

The debate over Public Funding

In July 2000 the government published its Plan for the National Health Service ("NHS"). Before considering this Plan, and its possible effects, we must put it into context. I will therefore first outline the situation as it stood prior to July 2000 and then list the changes that the Royal Commission wanted to make.

The situation prior to July 2000:
The most important feature of the UK system is the split between medical care (including nursing) and other aspects of LTC such as bathing, dressing etc—which we call "personal care."

Medical care is provided by the NHS and is free at the point of service, being funded from general taxation. Personal care has always been the responsibility of the Social Services departments of local governments. Eligibility for these services depends on a "wealth test." Such a system leads to many problems.

The first problem is one of *consistency* in interpretation. Not surprisingly the financial constraints on the NHS can lead many health authorities to adopt different interpretations of their duties. In addition, different local governments apply the "wealth test" in different ways, depending on their own financial situation and on the demand for services.

The second major difficulty is *public confusion* over what the state is providing. Many people, particularly the current retired generation, believe that the NHS was created in 1947 to provide a "cradle to grave" system and do not understand (or accept) this split between medical and personal care. The confusion was made worse because eligibility to free nursing care actually depended on where you are—rather strangely only if you were living in a nursing home did you no longer become the responsibility of the NHS and instead get passed to local government.

A final major difficulty is the *gaps in the services* being provided. The lack of funds means that there is significant unmet need for LTC. Approximately 5.7 million people in the UK give informal, or unpaid, care to relatives, friends or neighbors—with 1.7 million giving over 20 hours of care a week. Even with this level of informal care there is evidence that there is still a large amount of care that is needed and is simply not being provided either by the public sector or through these informal routes.

The Royal Commission's Report:
As a consequence of this unsatisfactory situation the Labor government set up a Royal Commission in December 1997 to investigate the funding and delivery of LTC. The Commission presented its Report in March 1999.

Its most controversial recommendation was to split the costs of LTC between living costs, housing costs and what they called the costs of "personal care". Only the first two should be subject to an "ability to pay" test, with all "personal care" being free at the point of need and funded from general taxation. The definition of "personal care" was wide, including not only nursing care but also all services which involves physical contact between the carer and the cared for.

This proposal would have radically changed the nature of LTC funding in the U.K., and not surprisingly it generated much controversy. There was also much debate over the accuracy of the financial projections used by the Royal Commission to cost their proposal.

The Government's Response and its Plan for the NHS:
The government rejected the Royal Commission's proposal to extend free services to all "personal care". Instead it confirmed that only "Nursing Care"—defined as services carried out by, or under the direct supervision of, a registered nurse would be funded from the NHS. All other aspects of personal care would continue to be subject to the "wealth test", with some small alterations. This introduction of free Nursing Care will be effective from October 2001.

Many of the less controversial recommendations of the Royal Commission are being acted upon. For example there is a new National Care Standards Commission which will be responsible for monitoring the quality of care being provided. In addition, in May 2001 a "National Service Framework for Older People" was published which sets out detailed targets for the amount and quality of care. For example there are requirements for the local NHS bodies to carry out regular screening and to maintain registers of those individuals deemed to be "at risk".

Although the government has rejected the idea of extending the scope of "free" services, it does recognize the primary importance of health care in LTC. In particular the NHS Plan includes significant funding, approximately £900 million, for intermediate care. This will include additional beds and other facilities to act as "step-down" care between the acute care being received in the NHS hospital, and the care available in a Nursing Home or other locality.

Other important developments that the government is carrying out include :

- The use of a single assessment tool for use by both the NHS and the local government agencies
- The use of "sticks and carrots" to ensure local NHS bodies and local governments cooperate in the management of care for the elderly
- The increased emphasis on prevention and rehabilitation which is a recurrent theme in the National Service Framework
- Increased financial and training support for the vital body of informal care givers.

"Many people, particularly the current retired generation, believe that the NHS was created in 1947 to provide a 'cradle to grave' system and do not understand (or accept) this split between medical and personal care."

Has this ended the debate ?

In short, No! The first difficulty is that the government in Scotland, exercising its new powers under Devolution, has adopted the Royal

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Commission's proposals of free personal care. This raises interesting problems about two different levels of public sector care existing within the U.K. It is very unclear how this will play out in practice. Further the actual costs of the Scottish solution will be viewed with great interest. Will it really be unaffordable, and if not, will England then be forced to follow Scotland?

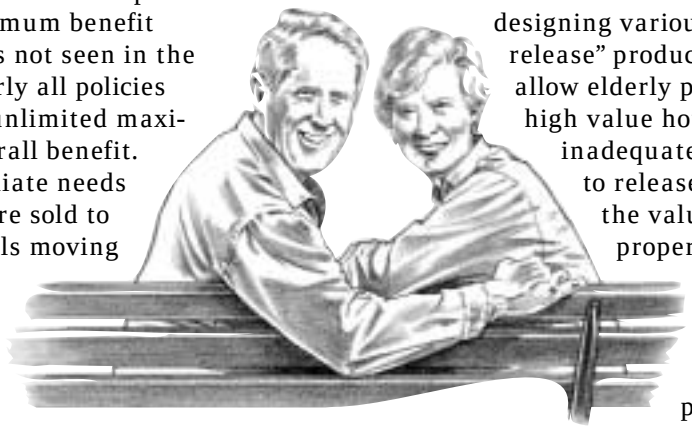
The second difficulty is that many pressure groups and political "think-tanks" do not appear to have accepted the solution in England. However the issue failed to damage the Labor Party in the elections this summer and so they will have no political need to amend their approach over the next five years.

The Role of Insurance and Financial Services

Despite the clear need for LTC insurance there are at present only approximately 35,000 insurance policies in force in the U.K. The following tables (Tables 4-6) show the "growth" of sales subdivided by the three categories of policies sold in the United Kingdom:

- Pre-funded regular premium
- Pre-funded single premium
- "Immediate needs" policies.

The first two are similar to products sold in the USA, with benefit eligibility determined with reference to failure of a certain number of ADLs. What is slightly different from the "typical" U.S. policy is a tiered benefit structure. Typically 50% of the maximum benefit is paid on failure of two out of six ADLs, with 100% payable on failure of three. A second difference is the emphasis on cash benefits rather than reimbursement of actual expenses incurred. Finally, the range of options seen in the U.S. as regards elimination period and maximum benefit amount is not seen in the U.K. Nearly all policies have an unlimited maximum overall benefit.



Immediate needs policies are sold to individuals moving into a nursing home and wanting to pay a single premium to an insurer to meet all future fees. This business is extremely competitive because of the ease of price comparisons.

Why have insurers not been able to translate the need for LTC insurance into a want ? Some of the reasons for this include:

- Lack of consumer knowledge on need
- Poor perceived value for money
- Marketing efforts concentrated at wealthy retirees
- General reluctance to insure
- Difficulties of a stand-alone sale
- The general uncertainty over the government's response to the Royal Commission
- Other more urgent problems facing the insurers (and their distributors)

The key question for the U.K. market is whether these difficulties are short-term and capable of being removed, or whether they are systemic to the U.K. My personal opinion is that the next three years will see the problems dissolve and sales of LTC insurance (using more innovative approaches) start to grow rapidly.

There is also much interest in designing various "equity release" products that allow elderly people with high value houses but inadequate income to release some of the value of the property for various purposes such as the purchase of LTC insurance, or care costs. Volumes of business are however still small. The government has launched a small scale pilot into public sector equity release. This allows local governments to make loans to individuals needing personal care but failing the wealth tests, secured on the individual's home.

Summary and Conclusions

This article has only been able to scratch the surface of this topic. Nonetheless I trust it has shown that there is a clear need for private LTCI solutions in the U.K. Actuaries should be able to play a leading role in helping to design and price products that meet this need.

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(Please refer to the supporting tables on the next few pages.)

Table 1

The demographics – UK population, m's

Year	Under 65	65-74	75-84	85+	65+ as % total	75+ as % total
1995	**49.4**	**5.1**	**3.1**	**1.0**	**15.7**	**7.0**
2011	**50.9**	**5.5**	**3.3**	**1.3**	**16.5**	**7.5**
2031	**48.4**	**7.7**	**4.8**	**1.9**	**22.9**	**10.7**
2051	**46.3**	**6.5**	**5.3**	**2.9**	**24.1**	**13.4**

Table 2

Number of people receiving LTC

Care at Home: (Population 65+ =9.1m)

- Community Nursing 530,000
- Day Care 260,000
- Meals 240,000

Institutional Care:

- Residential homes 288,750
- Nursing Homes 157,500
- Hospital 34,000

Source – Royal Commission ("RC") Report

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Table 3

The costs of LTC – formal payments

Type	National Health Service ("NHS")	Social Services	Private to Social Services	Private Direct Pay	Total
Home Health	**945**	**1,300**	**165**	**315**	**2,725**
Residential Homes	**-**	**1,910**	**1,030**	**1,200**	**4,140**
Nursing Homes	**195**	**1,300**	**530**	**750**	**2,775**
Long-stay Hospital	**1,425**	**-**	**-**		**1.425**
	2,565	***4,510***	***1,725***	***2,265***	***11,065***

Table 4

Statistics – Pre Funded Regular Premium

	New Policies	New Premium £000
1995	**2,942**	**2,333**
1996	**3,575**	**2,937**
1997	**2,841**	**2,552**
1998	**3,040**	**2,786**
1999	**2,055**	**2,050**
2000	**1,899**	**2,114**

Table 5

Statistics – Pre Funded Single Premium

	New Policies	New Premium £000
1995	1,963	30,401
1996	4,505	69,178
1997	3,740	62,455
1998	3,672	63,701
1999	2,959	59,889
2000	2,053	45,837

Table 6

Statistics – Immediate needs

Point of Need	New Policies	New Premium £000
1995	135	6,145
1996	127	5,308
1997	180	7,439
1998	280	11,585
1999	534	18,763
2000	743	27,655

- NB: (excludes PAFS data and other Impaired Life Annuities – source is ABI)