



International Association for the
Study of Insurance Economics

Études et Dossiers

Extract from

Études et Dossiers No. 348

**5th Geneva Association Health & Ageing
Conference**

**Long Term Care –
Risk Profiles, Determinants and Financing**

6-7 November 2008
London

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November 2008

**Working Paper Series of
The Geneva Association**

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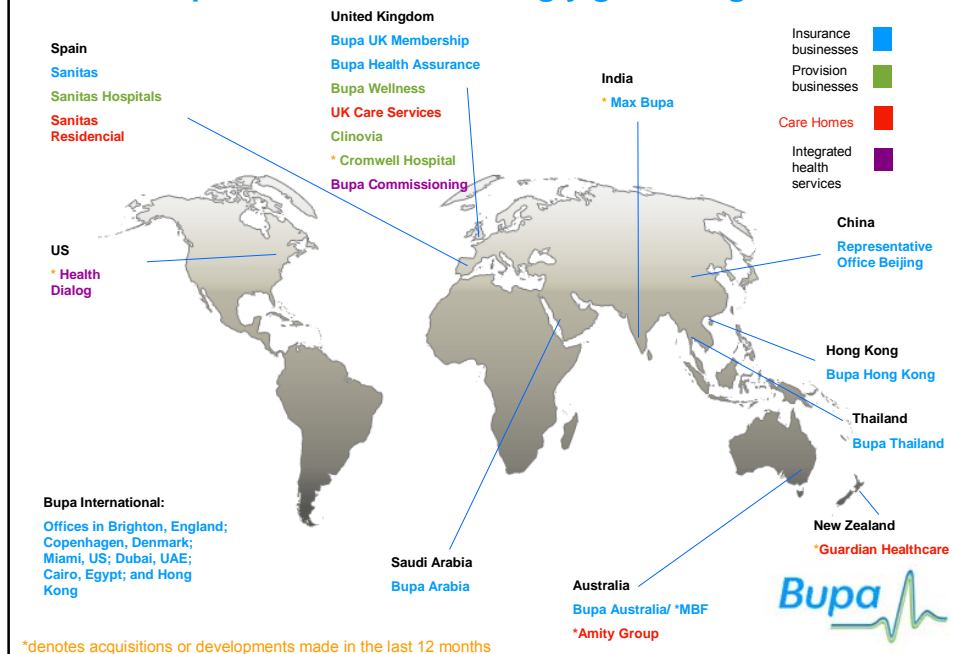
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Layout & Distribution: Valéria Kozakova

Long Term Care – Risk Profiles, Determinants and Financing. Perspectives from Bupa’s Experience

Clive Bowman

Recent acquisitions: an increasingly global organisation



United Kingdom

- BUPA Care Homes
 - 304 homes
 - 19,000 residents
 - 26,000 staff



Australasia & Spain



• Bupa Aged Care Australasia

- Amity is the second largest for-profit provider of residential aged care in Australia operates 49 facilities with 3,975 beds
- Guardian is the largest for-profit private hospital and rest home owner/operator in New Zealand operates 48 facilities with 3,045 beds



• Sanitas Residencial

- operates 43 care homes in Spain:
- 5,423 beds
- 2,300 employees
- Turnover of 85 million euro
- Second largest provider in the Spanish market



Setting the scene

Demand for long-term care will increase substantially in coming decades

New Demographics: Increasing longevity reduced fertility

New patterns of morbidity and dependency

Everyone's an expert (well experienced !) but few anticipate needing care

I must be getting old!

Every name in my phonebook ends with M.D.

www.california.com/GeezersShop



Uncertainties

- Ignorance / difficulty in predicting care needs
- Tension between defining standards and reconciling costs
- Variation of family care / desire to safeguard inheritance
- Financing/ Funding / Lack of advice / Capability



Ageing: The two tribes



Ageing well

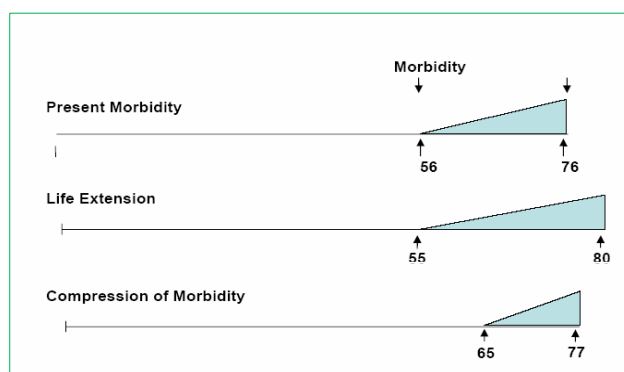


Burdened ageing



Morbidity compression

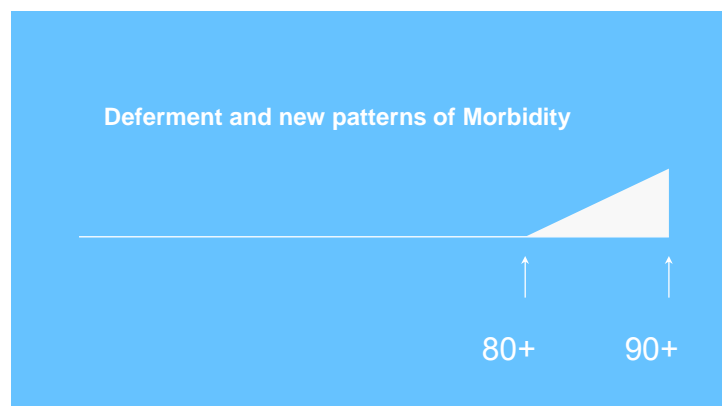
The average length of life has risen from 47 to 73 years in this century, but the maximum life span has not increased. Therefore, survival curves have assumed an ever more rectangular form.



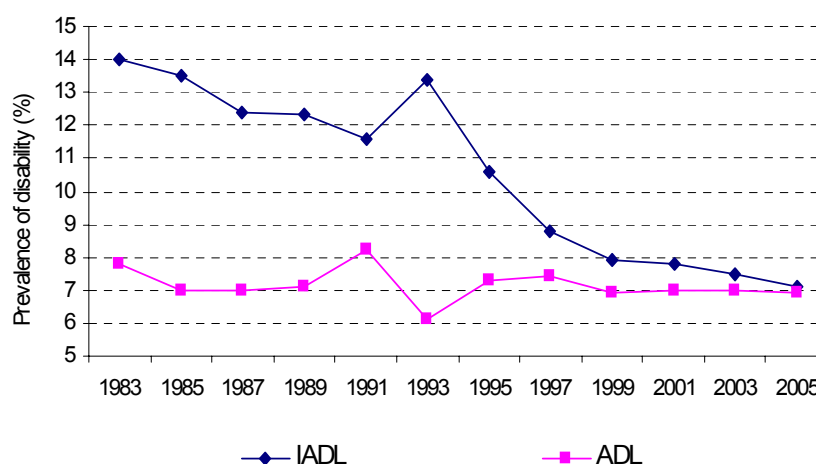
JF Fries: Aging, natural death, and the compression of morbidity
 NEJM 1980 303 130-135



The emerging reality of morbidity compression



The prevalence of disability among the non-institutional population aged 70 or more years,



Schoeni, Freedman and Martin 2008, 'What is late-life disability?'
The Milbank Quarterly, 86, part 1, 47-89.



The last year of life: mortality, cause of death and need for help among old men

- Proportional risk of death from heart disease or cancer declined with age.
- Independence from care and support greater when dying from heart or malignant disease
- 5-10 fold difference in need for care and support dependant on diagnosis

Finnish cohorts of Seven countries study

186 men, age range 65-89

Viitasalo V, Nissinen A, Kivinen P. & Takala J
Scandinavian J. of Social Medicine 1996 24(2) 132-9



International percentages of older people in LTC institutions and receiving home care

Country	Source year	Share of population aged 65+ in institutions (% of total) ¹	Share of population aged 65+ receiving formal help at home (% of total) ²
Australia	2003	6	21
Austria	1998	5	24
Belgium	1998	6	5
Canada	1993	6	17
Denmark	2001	9	25
Finland	1997	5	14
France	1997	7	6
Germany	2000	4	7
Israel	2000	5	12
Japan	2003	3-6 ¹	8
Netherlands	2003	9	13
Norway	2001	12	16
Sweden	2001	8	8
England	2003	5	4
United States	2000	4	9

Securing good care for older people
Wanless King's Fund March 06



Confounders

- Housing with care vs. Care with housing
- History of Institutionalisation
- Disease Management vs. Personal Care
- Prevention vs. Anticipation
- Choice and Personalisation



Long term care, personal and political issues



- The ignorance of risk
- The fear of care and its cost
- The political infeasibility

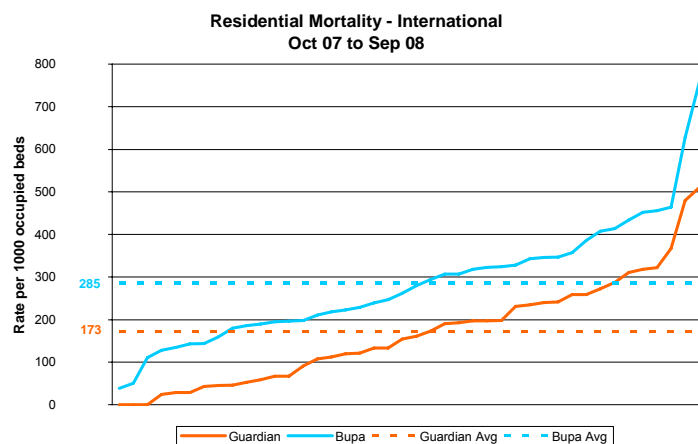


Never judge a book by its cover

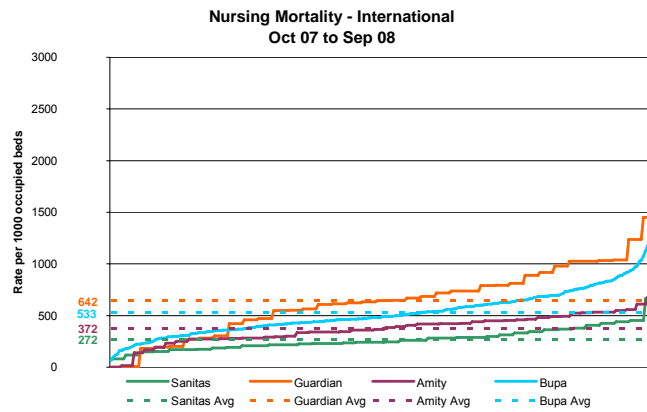
The buildings may be similar but.....



Mortality in Residential Care Homes



Mortality rates in Care Homes with Nursing



Care home resident dependency 2003

Bowman, Whistler & Ellerby Age and Ageing November 2004


	Residential	Nursing	Overall
1. Mobility	n=3894	n=11335	n=15287
Ambulant	40% (1566)	18% (2059)	24% (3642)
Ambulant with assistance	43% (1687)	28% (3228)	32% (4933)
Entirely dependent	16% (641)	53% (6048)	44% (6712)
2. Mental State	n=3849	n=11104	n=15015
Normal	31% (1175)	19% (2110)	22% (3295)
Confused or forgetful	60% (2319)	65% (7231)	64% (9591)
Challenging behaviour	11% (423)	23% (2549)	20% (2989)
Depressed or agitated	12% (479)	21% (2352)	19% (2840)
3. Continence	n=3832	n=11278	n=15166
Continent	53% (2044)	20% (2253)	28% (4311)
Urinary incontinence only	24% (930)	19% (2151)	20% (3089)
Faecal incontinence only	1% (45)	1% (95)	1% (141)
Urinary and faecal incontinence	21% (813)	60% (6779)	50% (7625)



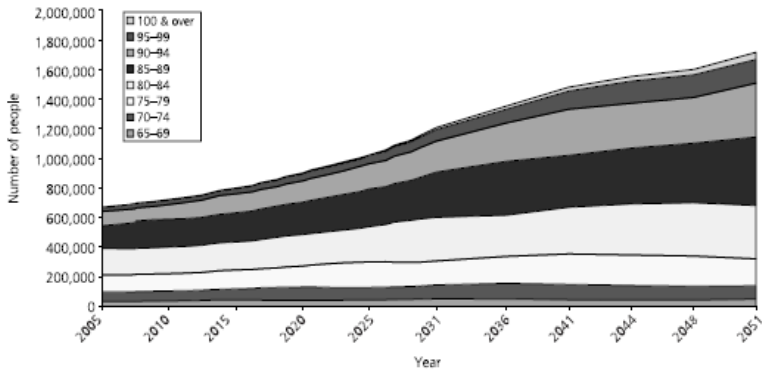
Why is this person in care?

	Nursing	Residential	All residents
Dementia	38% (4272)	31% (1164)	36% (5456)
Frailty	22% (2499)	34% (1282)	25% (3799)
Stroke	25% (2827)	12% (453)	22% (3287)
Sight Impairment	12% (1349)	16% (600)	13% (1958)
Arthritis	12% (1392)	15% (560)	13% (1957)
Family / Social Reasons	9% (968)	20% (773)	12% (1748)
Heart	10% (1160)	10% (382)	10% (1547)
Diabetes	9% (993)	7% (284)	8% (1280)
Hearing Impairment	6% (695)	9% (328)	7% (1025)
Depression	6% (673)	8% (319)	7% (998)
Other	7% (766)	6% (222)	7% (992)
Fractures	7% (777)	4% (167)	6% (951)
Parkinsonism	5% (613)	5% (187)	5% (807)
Lung or Chest Disease	5% (519)	4% (144)	4% (664)
Cancer	5% (508)	4% (139)	4% (651)
Osteoporosis	4% (459)	4% (142)	4% (604)
Epilepsy	4% (400)	2% (81)	3% (481)
Unknown	2% (177)	6% (214)	3% (392)
Neurological Trauma	2% (201)	1% (26)	2% (229)
MS	2% (207)	1% (19)	1% (226)
Learning Difficulties	1% (167)	1% (54)	1% (221)
Housing	1% (130)	2% (90)	1% (220)
Schizophrenia	1% (167)	1% (40)	1% (208)
Missing Limb	1% (165)	1% (43)	1% (208)
Manic Depression	1% (81)	1% (38)	1% (119)
Motor Neurone	0% (50)	0% (3)	0% (53)
Huntingdon's	0% (45)	0% (7)	0% (52)
Cerebral Palsy	0% (38)	0% (9)	0% (47)

Bowman, Whistler & Ellerby 2003 Census BUPA Care Homes
Age and Ageing November 2004




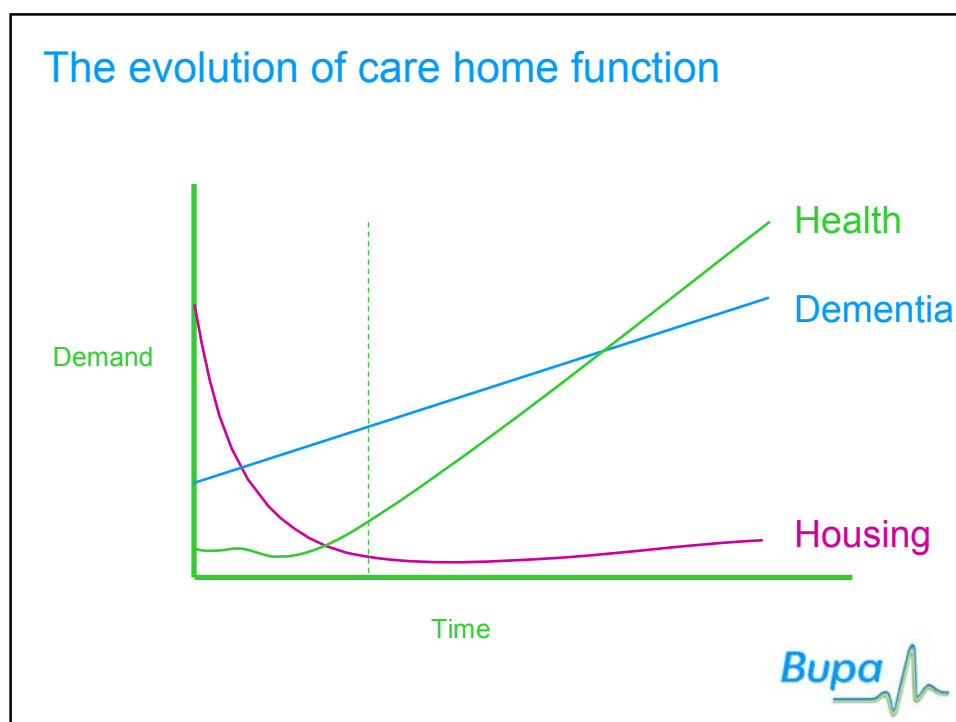
The increasing impact of Dementia



Projected number of people with late-onset dementia by age group (UK)

Dementia UK





Common ground: *Long Term Care Funding in some Key Geographies*

1. Every country believes that an individual should make at least some funding contribution towards the costs of their care (whether this be for personal / nursing care or accommodation)
2. Every country supports the notion that nursing care should be funded by the government
3. In every country a system is in place to provide care to the poorest in society- those with assets and savings below a minimum threshold (varies between countries)
4. UK / Australia / US use a means-tested approach to determine the amount an individual contributes towards their care. Spain's new system provides universal entitlement irrespective of means
5. Every country has some form of private / non-government funded care homes- whether it be assisted living units (US, Canada), retirement villages (UK, Australia), care villages (US), or private for-profit homes (Spain)
6. In the US and UK, if you have funds over a certain threshold then you are expected to pay the full cost of your care (excluding nursing care) – that is, “spend down” your assets until you fall below the threshold and qualify for government support



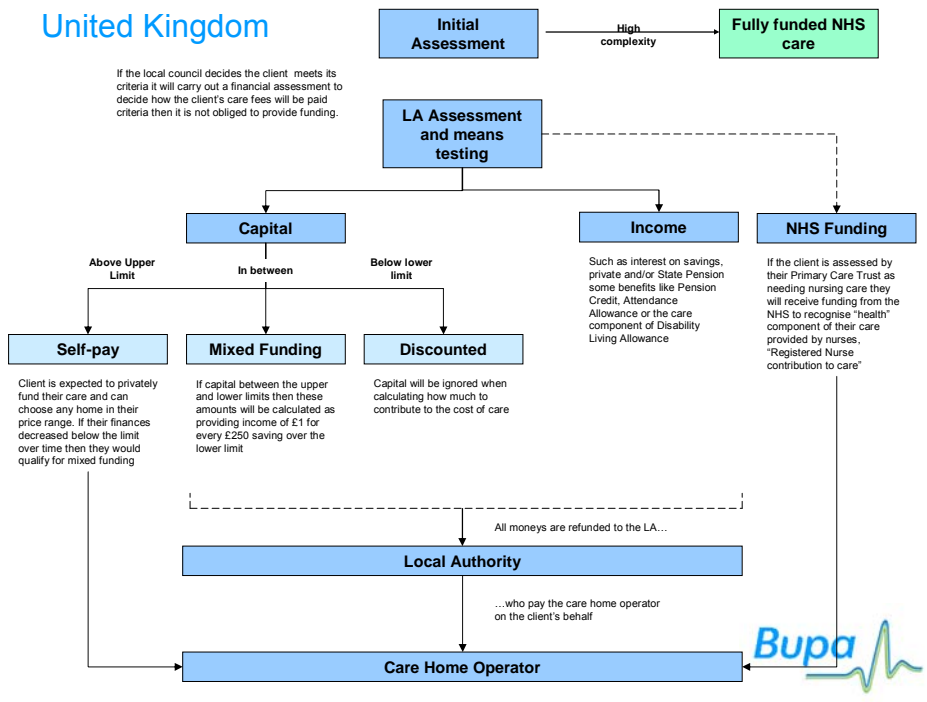
Eligibility assessment problems (international)

- Multiple assessments
- Inappropriate metrics and application
- Gaming
- Little or no data collection and analysis

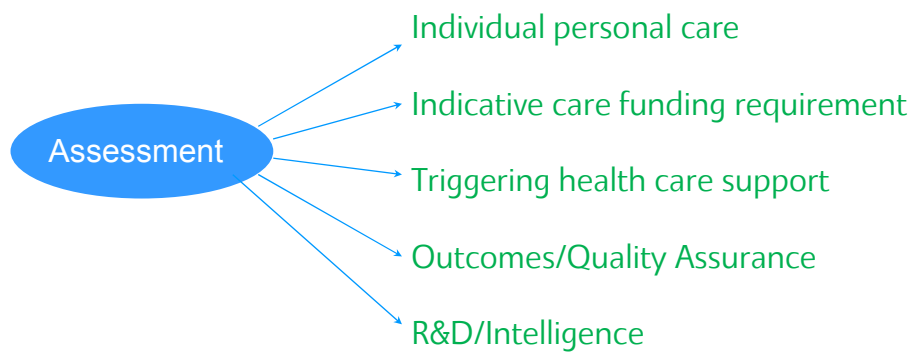


United Kingdom

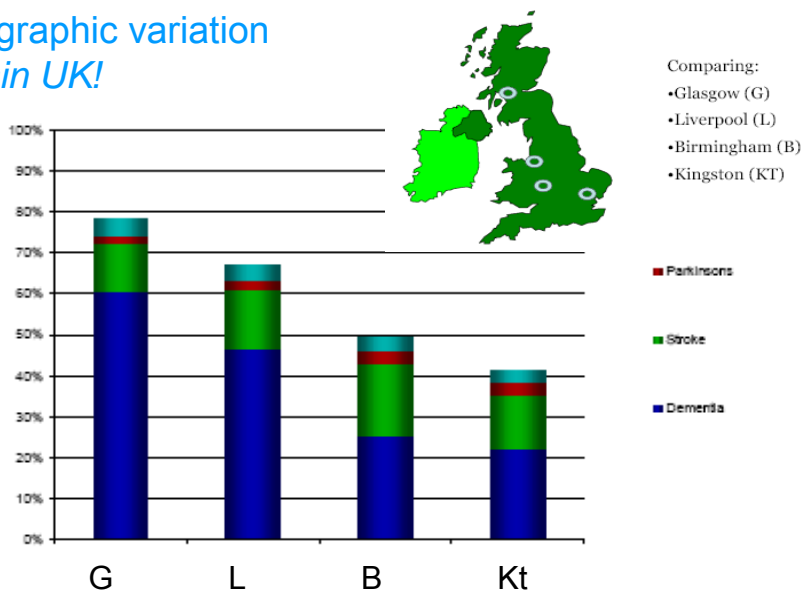
If the local council decides the client meets its criteria it will carry out a financial assessment to decide how the client's care fees will be paid criteria then it is not obliged to provide funding.



What assessment should deliver



Geographic variation *Within UK!*



CCC Census 2006



The German distribution of LTC benefits

3 Benefit bands for long term care insurance

Grade I Support is necessary for at least two activities in the area of body care, eating and mobility (at least once daily) as well as housekeeping (at several times a week) with an overall average duration of at least 90 minutes daily.

Grade II Support is necessary at least three times daily with an overall average duration of at least 180 minutes daily.

Grade III Support is necessary around the clock including nights with an overall average duration of at least 300 minutes daily.



UK background to LTC insurance

- Arrival of long-term care insurance (LTCI) in the UK coincided with the NHS and Community Care Act 1990, preceded by the *Caring for People* Griffiths Report 1989
- Levels of uptake relatively low compared with market expectations. Commentators said that the insurance products were complex, expensive and represented poor value for money
- Primary cause of the very low uptake on these plans was, and is, the uncertainty over what the State will provide
- Over the course of 2004, the main providers of LTCI withdrew most of their products from the market



Funding mechanisms for LTC UK

- Insurance plan, also known as a pre-funded plan, which paid a benefit when the customer could no longer perform a number of ADLs
- Investment plan that was intended to provide a lump sum, or return of capital, over and above the protection element of the plan
- Conversion option, which was tacked onto a mainstream protection policy such as a critical illness plan
- Immediate needs annuities that offer enhanced rates because the purchaser will most likely have a lower life expectancy than the norm



UK LTC insurance volumes

Year	New policies			In-force policies		
	Pre-funded	LTC Bonds	Immediate needs	Pre-funded	LTC Bonds	Immediate needs
1998	6712	-	280	28379	-	737
1999	5014	-	534	32421	-	1205
2000	2535	1573	789	24629	10252	1852
2001	2991	1044	1316	26909	12406	2662
2002	2851	581	1499	28628	12703	3111
2003	2484	247	1506	29669	12777	3658
2004	*	*	1730	29342	11237	4342
2005	*	*	1285	27346	9798	4303
2006	*	*	1229	26069	9979	4414
2007	*	*	1127	24701	9522	4339

[†] LTC Bonds included as pre-funded prior to 2000
^{*} not reported to protect anonymity (less than three companies supplying data)



The case for & welfare gains of LTC insurance

- Assume:
 - High-quality long-term care costs £30,000 per year
 - One in six people need long-term care and, if so, need it on average for two years. Thus typical person needs long-term care for one-third of a year
- If there is no insurance, a person has to save enough to cover the *maximum* duration, e.g. 20 years at £30,000 per year = £600,000
- With insurance, a person has to save enough to cover the *average* duration, e.g. 1/3 year = £10,000
- Thus the welfare gains from insurance are large and obvious. Insurance clearly dominates self-insurance

Nicholas Barr 2008
London School of Economics
<http://econ.lse.ac.uk/staff/nb>



Social Insurance (managed by private sector)

- Taxpayer finance: unsustainable (at least in England)
- Self-finance: an inferior solution: insurance is superior to self-insurance
 - Actuarial private insurance: technically badly suited to the risks involved in long-term care
 - Social Insurance looking attractive

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The importance of policy leadership and adequate resources

- Government funding for publicly-funded residents needs to match the increases in the real cost of care or homes will close
- The government can't impose cost drivers - higher pay or better quality standards - without commensurate increases in funding for providers.
- The current "cake" of money is inadequate



Bupa 

What is needed

- Acceptance of the need and role of care
- Clear and sustainable Government policy for managed reform and stability
- Overall funding settlement for care needs to be assured and proportionate to need
- Eligibility assessments should be transparent and of a proven metric
- Financing of care needs to be simple, personal navigation and financial advice much needed
- Private pay, public funding and the role of insurance need a level playing field

Bupa 

What I think about

- The potential for critical illness policies for later life especially dementia
- “Top up” insurance for upgrades
- Older people tend to be shunted around systems there needs to be a real citizenship to long term care policy
- Not solving this challenge will be more expensive than being brave!

