



ROYAL LONDON POLICY PAPER 19
Is it time for the “Care Pension”?

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IS IT TIME FOR THE “CARE PENSION”?

Executive Summary

With the over 85s being the fastest growing section of the population, resolving the issue of funding of long-term care is becoming ever more urgent. Yet despite more than twenty years of Royal Commissions and expert reviews, we seem to be no nearer to a solution. A Green Paper is expected in the coming months which will undoubtedly summarise the nature of the problem and ask some searching questions, but the recent General Election campaign suggests that there is little prospect of political consensus on a way forward.

The purpose of this paper to suggest that a new financial product – the care pension – could be part of the solution. It combines the increasingly popular ‘drawdown’ account which more and more people are using to fund their retirement, with a care insurance element. To make the product a success, two changes would be needed from government:

- Withdrawals from the drawdown account to pay for the care insurance element would need to be tax free;
- There would need to be a lifetime cap on care costs (such as the one proposed by the ‘Dilnot Commission’ and as provided for in the 2014 Care Act), so as to increase the willingness of financial services providers to offer the product;

If these two changes were made, this paper argues that many of the barriers to the sale of long-term care insurance products in the past could be overcome. Indeed, the product could be regarded as a form of ‘inheritance insurance’ rather than ‘care insurance’. Those who were covered by a policy could be confident that if they needed to fund large amounts of care in later life these bills would be taken care of and there would be no risk that the value of the family home would be needed to fund care costs instead of being passed on to the next generation.

A new market in care insurance would not solve all of the problems of the care system, particularly for those who already had advanced care needs. But it would progressively increase the proportion of people who were pooling the risk of facing ‘catastrophic’ care costs and would reduce the future call on the state to meet these needs. As the Dilnot report points out, the risk of catastrophic long-term care costs remains one of society’s last great ‘unpooled risks’. The care pension could be part of the solution, and we hope that this paper will help to stimulate discussion of this idea.

1. What is wrong with the current system of funding social care?

The issue of social care funding has been a hot political topic for the last twenty years or more but with no resolution.

In 1999, a Royal Commission on Long-Term Care proposed a new system of free nursing and personal care, but its recommendations were not implemented. Since then a series of reports has been undertaken, most recently the ‘Dilnot’ commission into the funding of care. Many of the proposals of this commission were included in legislation but they are still to be implemented. Earlier this year a new set of proposals for funding care was included in the Conservative party manifesto but proved to be highly contentious. We are now promised a ‘Green Paper’ which will start the whole process of consultation over again. So, what is the problem that we are trying to solve?

Paying for long-term care has become an issue primarily because we are living longer. In the past, we may have needed acute health care for a limited period later in life, but few of us would have lived on for decades needing growing help with the basics of daily living such as getting dressed, feeding ourselves and so forth. Whilst “health” care is pretty comprehensively covered by a pooled national health service, “social” care has not been within the scope of that arrangement. Instead, individuals have largely had to fund their own care, with those who have no assets able to apply for means-tested support from their local authority¹.

There are many problems with the social care system as a whole, including poor co-ordination between health and social services, a lack of focus on prevention and huge strain on local authority budgets resulting in increased rationing of care. But with regard to the funding of care in particular, the biggest issue is the ‘lottery’ of care costs.

In essence, as the Dilnot report pointed out, care costs are the last big ‘unpooled risk’. With regard to most of the other catastrophic risks that we can face, insurance is either mandatory (eg car insurance), extensively taken up (eg home insurance) or provided by the state through a type of social insurance (eg the NHS). But the risk of facing catastrophic care costs running into many tens of thousands of pounds falls largely on the individual. For those who would not fall within the scope of state support, some can find most or all of their lifetime wealth wiped out by later life care costs, whilst others – such as those who die suddenly – can face zero care costs. As things stand, there is no means of pooling this risk.

One obvious option, and an approach adopted to varying degrees in other countries, would be a form of social insurance. Under this approach, individuals pay in through their taxes or social insurance contributions and then social care is available on the basis of need rather than ability to pay.

Whilst this approach can work well, it would be fair to say that there has been limited political appetite in the UK for a ‘national care service’ analogous to the NHS. Given that the state already faces very considerable unfunded future costs of paying for state pensions, public service pensions, health care and social care for those unable to support themselves, there seems to be little appetite for the large tax increase that might be needed to introduce a

¹ Funding arrangements do however vary between different parts of the United Kingdom. In particular, limited free personal care is available in Scotland.

system of social insurance for care. In addition, given that the main beneficiaries would be those on middle and higher incomes (since those on low incomes can currently get help with their care needs) this might not be seen as being a social priority.

However, it remains the case that the risk of catastrophic care costs remains a lottery and it is one that particularly affects those with chronic but not automatically life-threatening conditions such as dementia. The people who face the highest costs are not those who have a serious condition and die suddenly but those who, in effect, ‘live with’ their condition for a prolonged period. So, if state provision is unlikely to expand beyond those with modest income and assets, could there not at least be a form of private care insurance which would allow those who wished to do so to pool their risk with others?

In the next section we consider why a market for care insurance has not really taken off and the barriers both to people wanting to buy care insurance and to insurance providers being willing to sell it, before going on to offer a potential solution later in the paper.

2. What puts people off buying insurance products for care costs and providers from providing them?

At first glance, the risk of facing huge and unexpected costs for long-term care in later life would be a perfect candidate for an insurance product. We insure ourselves collectively against the risk of our home burning down by buying home insurance, against the risk of a terrible car accident through motor insurance, against the risk of expensive medical costs through a state-run health service complemented by private medical insurance and so on. Yet, with one main exception², very few care insurance products are sold in the UK, and providers who have offered such products in the past have generally pulled out. So what are the barriers to individuals buying care insurance and to insurers offering such products?

i) It feels expensive

There are a number of reasons why insurance against future costs of long-term care can seem very expensive.

The first is that potential care costs can run into many tens of thousands of pounds, especially for those who spend years in later life in residential care. For example, the average cost of a week in a residential care home is currently around £600, and the average stay is currently around 130 weeks. For someone needing residential care in later life, a typical bill could therefore easily reach £70,000-£80,000. With a risk of between 1 in 3 and 1 in 4 of a person needing residential care later in life, the total cost of insurance is likely to be expensive.

A second, and linked, reason why insurance policies can be expensive is that a small number of people can face exceptionally large costs if their stay in a care home is particularly long. Insurance companies need to raise enough in premium income to cover a small number of exceptionally expensive cases – the so-called ‘tail of the distribution’ – and this adds considerably the cost. It is partly for this reason that the 2011 ‘Dilnot’ report³ recommended a cap on lifetime care costs to which an individual could be exposed. Such a cap would reduce the cost of providing insurance and would make it more likely that providers would enter the market.

A third problem is that those who take insurance tend to spend longer in care homes than those who do not. Insurance companies cannot base their cost estimates on averages but need to take account of the fact that the insured care home population has higher average expected durations of stay.

Fourth, current low interest rates make providing a product of this sort relatively expensive. If individuals pay premiums to an insurer who invests those premiums so that there is a pot of money to pay out care costs years down the track, low interest rates mean that investment returns only make a small contribution to the overall financing of the product. Most of the money has to come from premiums.

² *The one main product which is sold is the ‘immediate needs’ annuity which is generally bought – in effect – at the door of the care home. Individuals who know that they face admission to a care home can buy a policy which protects them against the risk of a long and expensive stay in a care home. A one-off premium for such a policy could cost as much as £100,000 however, and it is thought that only a few thousand policies are sold each year.*

³ See <http://dilnotcommission.dh.gov.uk/>

Finally, there is some evidence from the US that individuals are reluctant to take out a policy which may not pay out. Just as some people object to buying an annuity on the basis that if they die young they have ‘lost the bet’, some people do not want to buy a care insurance product if they feel that they will ‘get nothing’ if they die without needing care. We consider potential solutions to this problem later in this paper.

ii) Lack of tax breaks compared with other financial products

Some financial products attract considerable tax advantages. With a pension, a saver can get tax relief on contributions at up to 45%, can see the money in their pension fund grow largely tax free and can withdraw up to a quarter of the accumulated fund tax free. With an ISA, although contributions into the ISA are made out of post-tax income, all further returns and withdrawals are untaxed. With a lifetime ISA, there is a 25% government top-up on contributions and there is no further taxation as long as withdrawals are made in line with the rules of the product.

By contrast, someone wanting to buy a traditional insurance policy to cover care costs would have to do so out of taxed income. Worse still, if they bought a deferred annuity which paid them an income if / when care costs were incurred, the income from that annuity would itself be taxed.

The one exception to this (and a point to which we will return) is that those who buy an ‘immediate needs annuity’ which involves an insurance company making payments directly to a care provider do *not* pay tax on the payouts on that policy.

iii) Not wanting to think about it

One of the biggest barriers to taking out insurance against incurring large care costs is that most people simply do not want to think about themselves at a stage of life where they cannot look after themselves. There is plenty of evidence that people put off buying pensions because they do not want to think of themselves later in life when they may be too old to work, but these psychological barriers are much more acute when it comes to a future in which you need to be cared for. Insurance products will be much more affordable if people take them out earlier in life, but most people do not want to face up to the reality of their potential future care needs. If the purchase decision is delayed until care needs become apparent, the potential for risk-pooling with those who do not have care needs has largely disappeared.

iv) Not appreciating potential costs

One of the things that regularly shocks family members when they have a friend or relative go into residential care is just how much it costs. As noted above, typical weekly bills for a residential care home are currently around £600 per week and for a nursing home around £840 per week, and these costs can quickly mount.

In addition, it is not just residential care costs which can quickly mount up. Consider an individual who needs someone to come to their home for an hour twice a day, once in the morning and once in the evening, seven days a week. Assuming an illustrative hourly cost of £15, this is £30 per day or £210 per week or over £10,000 per year. Given that individuals can live in their own home with carers coming in for many years, even domiciliary care bills can easily run into many tens of thousands of pounds. Few people appreciate the potential scale of such costs.

v) *‘The state will pay’*

A fundamental barrier to taking out a care insurance policy is the assumption that, if you need looking after, the state will pay in any case. In other words, it is often far from clear exactly what you are insuring. Many people are largely unaware of the difference between access to the NHS, which is overwhelmingly free on the basis of need, and access to social care, where state funded provision is heavily rationed on the basis both of need and of income and wealth. Whilst precise estimates are hard to come by, it is estimated that perhaps 20,000 families per year have to sell their family home ‘to pay for care’, which is a reminder that in many cases the state **will not** pay for your care unless you have run down your own resources.

Even in cases where the state will ultimately pay for care, the nature and extent of that provision may well be less than many individuals would want for themselves. For example, recent research by the University of Newcastle⁴, found that for younger pensioners with care needs in particular, access to residential care has been substantially reduced in recent decades. Those who are reliant on the state may find that they have to wait for a care home place much longer than they would wish.

In addition, local authority budgets are under great strain and most local authorities have a limit on the amount they will contribute to care costs for those with no other means of payment. This means that in many areas the local authority rate will not cover the cost of all care homes in the area and an individual with no other means of support will face a severely restricted choice of provision.

For those in most need, the state will generally pay, however it will expect the individual to have used most of their own resources first. This sets quite a high threshold of need before help kicks in and may provide a very limited choice of provider. By contrast, if individuals had private insurance for care costs they could be confident that their assets (such as the value of the family home) would be protected rather than required by the local authority to be spent down before help could be given.

vi) *The challenge of buying / selling a freestanding ‘care’ product*

Each financial product has its own set of rules and regulations, different tax treatments, different market segments, different sales channels etc. Long-term care products can be quite sophisticated financial products and there is much to be said for taking financial advice before buying one. At present however, financial advisers who want to provide advice on long-term care products have to have a specialist qualification. This limits the number of advisers and potentially the size of the market.

In the next section we consider whether a new financial product might be able to overcome a number of these problems.

⁴ [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31575-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31575-1/fulltext)

3. Overcoming the barriers to care insurance – is it time for the ‘Care Pension’?

a) Introduction- the impact of ‘freedom and choice’

Since April 2015, individuals have had much greater freedom about how they use their accumulated pension saving. Before this date, many people who built up a pension pot handed it over to an insurance company in exchange for an income for life – an annuity. But under the ‘freedom and choice’ reforms, individuals now have a wider range of alternatives to an annuity. In particular, more people are now leaving their money invested for longer and drawing income as and when they need it from a ‘drawdown’ product. The latest figures⁵ from the Financial Conduct Authority (FCA) suggest that before the reforms 90% of all pension pots were used to buy an annuity. But in 2015-16 (the first full year of the reforms) the Association of British Insurers reports that a total of 90,000 drawdown products were sold worth £6.1 billion, compared with 80,000 annuities worth £4.2 billion⁶.

Part of the reason for the growth in drawdown is the large numbers of people who are converting their Defined Benefit (or ‘final salary’) pension rights into Defined Contribution rights. A recent Royal London survey indicated that a typical advised transfer would be for a value of between £250,000 and £500,000. One of the main reasons why such transfers are taking place is because individuals want a capital sum that would be available to their heirs when they die.

The fact that growing numbers of people who in the past would have had an annuity (or a DB pension) now have a drawdown account offers the potential for a new way of encouraging individuals to put money aside to pay for care needs in later life.

b) Integrating care insurance into a pension product

The way that drawdown products work is that individuals leave their assets invested but make withdrawals from the account in line with the terms of the product. Clearly, this is not as certain as an annuity and the value of the money in the pot can go down as well as up. Most drawdown products are sold with financial advice and advisers often have an ongoing role in helping individuals to manage their drawdown account so that they do not run down their money too quickly and leave themselves with too little later in retirement. Many people open a drawdown account in their late 50s or early 60s.

This product structure suggests that it would be relatively straightforward to integrate a care insurance element. There are various ways in which this could work, but a simple model would be that the policy holder commits to pay a regular insurance premium directly from the drawdown account to the product provider. In return for this, the product provider would guarantee to pay a certain amount into a ‘care account’ in the event that an individual had care needs above a certain threshold. Money from this care account could be used to pay for approved care costs (eg home carers or residential care) in line with the wishes of the policy holder.

Crucially, it is proposed that the payments from the drawdown account to the product provider would not be taxed. At present, money taken out of pension saving is generally taxable apart from a 25% tax free lump sum. Under this proposal, the money would leave the

⁵ <https://www.fca.org.uk/publication/market-studies/retirement-outcomes-review-interim-report.pdf>

⁶ <https://www.abi.org.uk/news/news-articles/2017/04/the-new-retirement-market-the-evolution-continues/>

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drawdown account but go direct to the insurer and would not be taxed. Money paid into the care account and then used to pay care providers would similarly not be taxed.

c) *How does this product help to overcome the barriers to taking out care insurance?*

- Spreads the cost

Care insurance could be an integrated part of taking out a drawdown product. If individuals take out a product around the age of 60 and do not typically incur significant care costs until their mid 80s, this spreads the cost of the policy over many years and makes it more affordable. If the care element was sold as part of the drawdown product this would reduce (though not eliminate) the need for a separate sales process with separate product literature etc. and this would reduce the cost of providing the product. In addition, if the premiums were collected as – in effect – a direct debit from the drawdown product, then this would be a relatively straightforward process.

If individuals were reluctant to take out the product because ‘it might never happen to me’, the policy could have some residual value in the event that the policy holder died before they needed to spend money on care. The policy could be presented as *either* paying out in the event of significant care needs or paying a lump sum in the event that you didn’t have care costs, or perhaps offering to meet funeral costs up to an overall limit.

- Offers a tax advantage

Unlike previous care insurance products, this one would have a tax advantage. Money you had saved into a pension (with tax relief) and which went directly to pay for care insurance would never be taxed. Nor would any payout from the policy. This is a direct analogy with the current situation where payouts from an immediate needs care annuity which go directly from a provider to a care home are not subject to tax.

HM Treasury is, understandably, rather wary of calls for new tax breaks as it assumes there will be considerable ‘deadweight’ cost – people who would have taken out a policy in any case now getting a tax break. But in this case, to be frank, there is no real market. The tax break would be helping to generate a new market and as a result there is little or no deadweight cost.

To go further, the Government ought to welcome the expansion of private provision for long-term care costs. Given that state provision is becoming increasingly rationed, more and more people will either have to rely on their own resources or go without provision. In the latter case this can mean increased strain on the NHS (as people with inadequate home care make increasing calls on NHS emergency services) and increased strain on family carers who may have to give up work to look after someone who cannot access state support. Greater private provision could reduce the burden on the NHS and on carers, as well as improving the quality of life of those needing care.

- You don’t need to think about it

With an integrated care and pension product, it could become a ‘social norm’ that when you retire you think about your income in retirement and how you might need future care needs. Particularly for those benefiting from financial advice, the option of a ‘care insurance’ element to a drawdown product would prompt a conversation about this issue. The box below also sets out one idea as to how this kind of product could be marketed much more

positively in a way which does not focus on a time of life that many people would prefer not to think about.

- Helps people to appreciate the cost

Even if a new care insurance product was available, it is fair to say that the lack of awareness among the public of potential care costs would remain a barrier. However, as our society ages and more of us have experience of the care costs faced by elderly parents or the elderly parents of friends and colleagues, this may gradually help people to appreciate the value of these products.

- ‘The state will pay’ – or will they?

One advantage of the current debate over paying for care is that people are increasingly appreciating that in many cases the ‘state’ will not pay. A recent report by the Care Quality Commission⁷ found that 1.2 million people were not receiving the care that they need, which suggests that growing numbers of people now have first-hand experience of the tight boundaries around state provision.

The recent Conservative proposal to include the value of the family home in the means-test for domiciliary care, for example, suggests that policy is likely to become more restrictive in future, with those who have assets being expected to make more of a contribution. Against this backdrop, more people will begin to realise that state provision is likely to be limited to say the least, and that their own financial assets are on the line if they do not have some form of cover.

In addition, local authority budgets are under great strain and most local authorities have a limit on the amount they will contribute to care costs for those with no other means of payment. This means that in many areas the local authority rate will not cover the cost of all care homes in the area and an individual with no other means of support will face a severely restricted choice of provision.

In short, whilst it is indeed the case that, for those in most need, the state will generally pay, it will expect the individual to have used most of their own resources first, it will set quite a high threshold of need before help kicks in and it may provide a very limited choice of provider.

- The challenge of buying / selling a freestanding ‘care’ product

The beauty of the ‘care pension’ approach is that the care insurance is simply an additional feature of an existing, and increasingly popular, financial product. Financial advisers dealing with retirement issues are already familiar with selling drawdown products and in many ways this would simply be a new product feature. There are already care-related variations on some existing financial products (eg ‘whole of life’ insurance policies which pay early if care needs arise), and this would be a natural extension of the drawdown concept.

⁷ https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1617_summary.pdf

Marketing the Care Pension

One way of overcoming the barrier of individuals not wanting to think about their care needs would be to present this product not as ‘care’ insurance but as ‘inheritance’ insurance.

We know that many individuals plan their finances carefully so as to reduce their liability to inheritance tax and, more generally, to ensure that as much as possible of their wealth is passed on to their heirs.

One thing that can get in the way of this planning is facing unexpected and large care bills. Someone without insurance can find that they have to sell the family home to pay for care or that bills can run into tens of thousands of pounds and can eat into the value of their estate.

But those with care insurance would find that they are no longer exposed to the risk of large and unexpected care bills. This means they could be more confident that, regardless of their care needs in later life, their family home and other assets would survive intact and available to be passed on to the next generation. Given that people are far more motivated to think about estate planning and looking after their children than they are to think about themselves in later life unable to look after themselves, it seems likely that describing this product as adding ‘inheritance insurance’ to a drawdown account would help to overcome some of the barriers to interest in the product.

4. Questions for further discussion

The basic premise of this paper is that the government should change the tax rules to allow withdrawals from drawdown accounts to pay for care insurance products which would be free from tax. If that basic principle was accepted, a number of further issues would arise for consumers, product providers and regulators. We offer some initial thoughts in this section, but hope that this paper will spark a wider debate where these issues can be debated more fully.

a) Nature of the product

In the description above, we have suggested that individuals would pay a regular premium from their drawdown account and that when care needs reached a certain threshold, payments would be made into a care account to cover care costs.

This simple idea could be varied in a number of ways depending on what most appealed to consumers and what made it cost-effective for providers to provide. For example:

- Lump sum premiums? - in principle, there is no reason why a care insurance policy could not be funded by a lump sum payment from a drawdown account as well as by a regular premium; insurers would no doubt wish to check that the individual who suddenly wanted to buy a policy with a lump sum was not aware of an imminent care need, but this kind of problem could be overcome by waiting periods / excesses etc.
- Nature of the benefit? – we have suggested that once a care threshold had been triggered, the policy would pay funds into a care account which would meet the full cost of care; but the policy would be a lot more affordable if the cover was only for a percentage of care costs or if the individual paid the first slice of care costs up to an agreed limit or if the cover protected the ‘final slice’ of an individual’s assets; there would need to be market testing of the type of cover which policy holders would most value; one attraction of having more people with ‘spending power’ to buy care services tailored to their needs is that it should trigger innovation in the care market, including greater use of new technology;
- What triggers the payout? – the insurance industry is already wrestling with the issue of how to determine who ‘needs’ care and would therefore qualify for a payout; one option would be to have a variety of levels of cover – a cheaper policy might pay out only when an individual had care needs which would trigger state support for those with no resources, whilst a more expensive policy could pay out earlier – perhaps when an individual started to want and value care rather than when the state necessarily thought they *needed* care; however, any link to state entitlement rules would be problematic since these are subject to change, especially over the lifetime of a policy running for many years
- What about people who make no claim? – as noted above, these products are much easier to sell if there is some ‘residual’ value whereby someone who never makes a claim on the policy gets a (modest) lump sum for their heirs. Obviously, the larger the residual value of the policy, the more expensive will be the policy.

- What if premiums stop? - if the premium for the ‘care pension’ is coming from a drawdown account, there would be a risk that at some point the account would be empty and premiums might cease; there would need to be provision to keep the policy live (for example by payments from other resources) and policy holders would need to retain some level of insurance cover even if they were no longer able to keep premiums going.

b) What would it cost the Exchequer?

Leaving aside the potential costs of the ‘Dilnot’ cap on lifetime social care costs, the main potential cost to the Exchequer of the Care Pension would be the loss of income tax on withdrawals made from drawdown accounts to pay for care insurance premiums. This is on the basis that most of this money would eventually have been withdrawn over the lifetime of the product and subjected to income tax.

However, a lot depends on how people manage their drawdown account. If savers reduced the regular income they draw from their policy by the full amount of the care insurance premium, then there would indeed be an immediate income tax hit. However, if savers only partially reduced their regular income and simply took larger overall withdrawals from their account, then the short-term income tax impact would be more modest. Clearly this would increase the risk that the individual would ‘run out’ of money later in life and this process would have to be managed.

Having said this, over time, having more people covered by their own care insurance would be likely to save the government money. If more people in later life are being properly looked after then this is likely to reduce the cost to the NHS and also the need to support family carers who have to step in where care is not in place. A full evaluation of the costs and benefits of this policy would certainly need to take into account long-term benefits of this sort.

c) Role of the state

As discussed earlier, one of the barriers to the provision of care insurance is the open-ended nature of the liability – the so-called ‘tail’ of the distribution of care costs; there is no doubt that the introduction of a ‘cap’ on lifetime care costs of the sort suggested in the Dilnot review would increase the viability of a care insurance product and would bring down costs

d) What to do in the meantime?

Realistically, a product of the sort described in this paper would be of most relevance to those approaching retirement. This group are potentially 20-30 years away from incurring significant care costs and therefore have time to pay in to an affordable insurance contract. For those who are already elderly and frail it is unlikely that this product would add much value, and relatively few of this group would have large balances held in drawdown accounts.

Conclusion

The need to find more funding for social care has become an increasingly pressing one. With the over 85s being the fastest growing section of our society, more and more citizens and their families will face the reality of potentially catastrophic social care costs. Yet at present there is almost no pooling of this risk beyond the means-tested state safety net.

A ‘care pension’ product, building on the growing use of ‘drawdown’ accounts in retirement, could help to overcome many of the barriers to care insurance. It would be integrated into a familiar product and could be marketed as helping people to protect their inheritance for future generations. A relatively simple change to tax rules would give the product a relatively favourable tax treatment which could help to spur the development of a market which has so far failed to take off.

Greater coverage of care insurance would be a win for all sections of society. It would help to ensure more people were able to afford high quality care later in life. It would give peace of mind to those worried that future care costs could leave them needing to sell their home and wipe out their hard-earned savings. And it would ease the pressure on increasingly stretched state-supported care provision, giving more individuals the resources to purchase their own care in a form that best met their needs.

There are no easy answers to the funding of long-term care, as the policy paralysis of the last twenty years demonstrates. But the care pension could be part of the solution, being more attractive to consumers than previous products and more attractive for providers to offer. With state support in the form of changes to the tax rules and a cap on lifetime care costs, the care pension could help to solve some of these intractable problems.

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