

LONG TERM CARE INSURANCE A Finnish Perspective

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ABSTRACT

Finland does not yet have Long Term Care Insurance. Public health services have so far been able to take care of the elderly, although public tariffing has left some people in a very difficult financial situation. The population is ageing, and with it the old age expenses are growing. The population is also getting lonelier with more single or childless people than ever before. Thus there will be a shortage of family caretakers in the future. Public opinion seems to be readier for private Long Term Care Insurance than before. The Minister of Health and Social Affairs has set a committee to further study Long Term Care Insurance and the possibilities for related tax benefits. On the other hand, Long Term Care Insurance is a problematic insurance from an actuarial point of view, so also the insurance companies have to consider the form and type of insurance they will be ready to launch. This survey is an abridged English version from a Finnish study on the need for, possibilities and difficulties of long term care insurance in Finland and on some of the European solutions already existing.

KEYWORDS

Ageing Population, Expenses, LTCL, Long Term Care Insurance, ADL, Activity of Daily Living, Finland, Europe.

1. Preliminaries

1.1. Introduction

Two Finnish reports have been completed on Long Term Care Insurance, namely "Vanhusten hoito ja hoitovakuutus, vakuutuksen hyödyntäminen vanhusten pitkäaikaishoidon järjestämisessä" (Elderly Care and Long Term Care Insurance, the Use of Insurance in Organising Long Term Care), which was prepared by a working committee appointed by the Federation of Finnish Insurance Companies. Another survey, funded by the Foundation for Promotion of the Actuarial Profession, was prepared to further study the subject. This text is an English abridged version of the latter survey.

Long Term Care Insurance, as described in this report, is not yet sold in Finland.

The report is based on a substantial amount of literature available on LTCI, and on statistics on the ageing population available in Finland and elsewhere in the European Union. Furthermore, interviews and discussions with the experts of Long Term Care Insurance in various insurance and reinsurance companies in Denmark, Belgium, France, Germany and Great Britain had a great impact on the Finnish report. The part describing Long Term Care Insurance in the said countries has mostly been left out of this version. There are several excellent reports in English on LTCI in Europe produced, for example, by a number of major reinsurance companies.

This report is not meant to, and it does not present exact, revised statistics. The purpose of any numbers included is to support the conclusions made. The spirit of this report is to describe and discuss what the Finnish society will look like in the decades ahead, and what kind of private care insurance solutions the elderly might benefit from then.

1.2. Background

In all European countries the proportion of elderly people is growing, and the growth in the number of elderly compared to the working population is rapid. Luckily, the increased life expectancy postpones the last, weak years of life, but on the other hand the outbreak of dementia seems to be fixed to an average age which is not growing. Hence the number of demented old people seems to be rising.

In Finland, the problem with the elderly is not and will not be worse than elsewhere in Europe. On the other hand, a special feature in Finland seems to be the proportion of single elderly people. There are more childless people and more divorced people in Finland than in most other countries in Europe. The number of women working full time is the highest in Europe. Distances are large and the working population concentrates to the few big cities, mostly around Helsinki. It seems that we have a specific Finnish problem: we are becoming a **nation of single senior citizens**. The problem will be then how to replace the missing next of kin.

1.3. General Features of Long Term Care Insurance

1.3.1. A Short Definition

Long Term Care Insurance is a product which compensates care at home or in an elderly people's home, as well as home repairs and aids which enable living at home when the person otherwise would no longer be able to manage on his own. The inability to perform the activities of daily living has to be permanent or long term, and its cause must be in accordance with the definition of the insurance policy. The activities of daily living are usually denoted by the abbreviation ADL.

The premium of a Long Term Care policy is moderate if the policy only compensates those situations where the insured is totally unable to manage on his own. Even less expensive it can be if the insured is expected to have a next of kin or other trustee who takes care of all the necessary arrangements of hiring help and paying for it or organising the repair of the house. The more expensive alternatives will provide for the services needed and include consultation with the customer in his everyday life already when not yet a claimant. The more flexible the definition of entitlement to benefit, the more expensive the insurance.

1.3.2. Aspects to Take into Consideration

Long Term Care Insurance should not be considered only as an economic issue. The insurable risk - not being able to cope with the activities of everyday life - has to do with our basic security and fundamental rights. Hence the evaluation of entitlement to benefit requires special attention and skills so that the claimant is not humiliated. After all, the claimant has bought the insurance as well as financial security, in other words a kind of as a psychological security of something to rely on when no longer strong and able himself. He has bought himself a right to dignity as well as a monthly compensation.

The insurance covers claims only when you are seriously and more or less permanently incapable of independent living. Thus the idea of luxurious independent living on an annuity from long term care insurance seems definitely false. A common feature would seem to be that once a claimant the customer very seldom recovers. Hence the period of payment is almost always incessant, i.e. till the death of the insured.

Long Term Care Insurance often provides services. This can mean help with planning your future once the entitlement to benefit has arisen, help with hiring a nurse or other home help, or choosing the most suitable nursing home. Insurances often compensate also repair costs for the house to enable living at home as long as possible. A customer may not need to use his own money at all. The most important thing, however, is that the customer gets a number where to call should he need help, any time of the day. The elderly of the future may find an Internet address or other new technique even more attractive. Regardless of the mode of contact, the insurance must provide the customer with a feeling of safety, of a "next of kin".

1.3.3. Why Long Term Care Insurance in Finland?

The need for private insurance seems clear only by looking at the growth in dependency ratio and economic dependency ratio. The costs of elderly care grow more rapidly than economics in general. The consequential economic pressure on the public sector can be relieved by private participation. There will, however, still be problems to be solved: low-income elderly and elderly in faraway locations will continue to need strong public participation in their expenses or in providing them with help. The number of old ones needing someone because of no next of kin will expand in all socio-economic classes. There will have to be someone to consult when the problems of growing old arise for all those people.

1.4. Concepts

Risk insurance, such as health insurance, is bought in order to get compensation when the entitlement to benefit arises. The entitlement is usually something that is sudden, unpredictable and limited. Here the entitlement means growing old - too old to cope on one's own. That, in fact, is not unpredictable but usually rather inevitable. Only the timing and length of the period (normally within 20 or at most 30 years) is unknown. Neither is the birth of entitlement usually sudden but slow. Hence it will be difficult to draw a line whether entitlement to benefit has arisen, whatever the definitions for the insurance are. Entitlement to benefit has arisen once the insured has become incapable of independent everyday living according to the terms of the insurance. Defining the entitlement to long term care is always difficult and requires extra discretion.

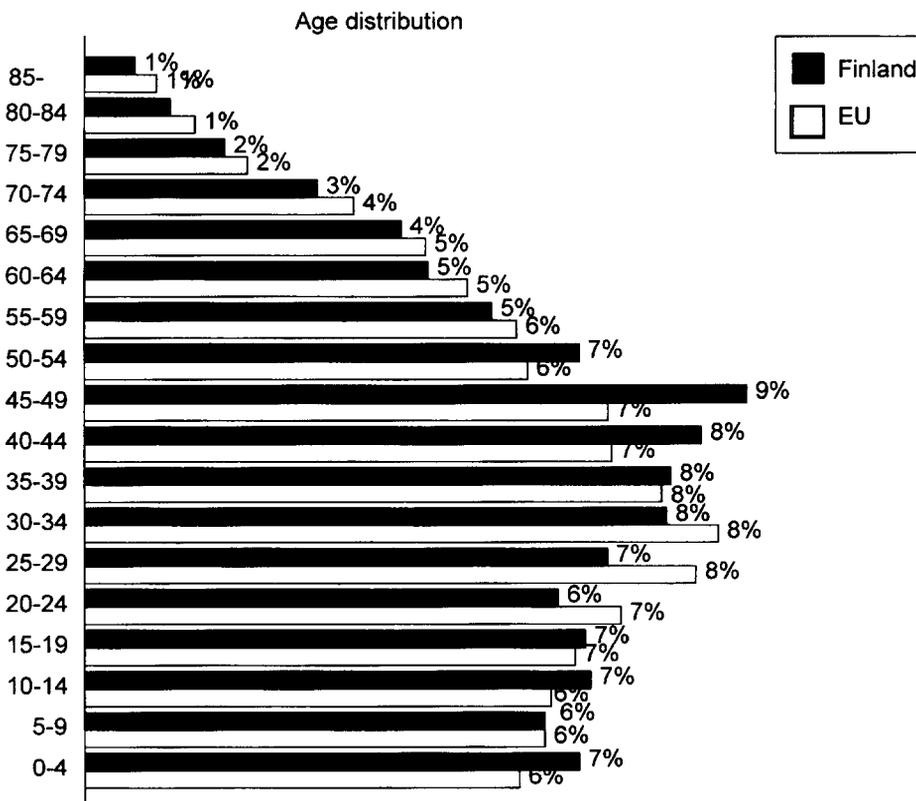
The premium of risk insurance is rated according to the risk. In long term care insurance the risk is usually evaluated for the whole life span and then divided into level premiums according to the age of the insured when the insurance is written. LTCI can also be designed as pension, investment or savings insurance. In such insurance you create a personal fund, which you are allowed to use under the conditions agreed on and for which you also are paid interest. Long Term Care Insurance can be risk insurance or a savings product or a mixture of these.

2. The Elderly Population in Finland

2.1. Age Structure of the Population

The average age of a Finn has grown by over 40 years during the last century. The maximum age, on the other hand, has not grown, and only very few people live to be a hundred years old. Because of the biological ageing process the person growing old gets weaker and slower. This means that the curing of illnesses does not conquer ageing. Still, a steadily growing number of people live up to 90-100 years and keep physically fit. The mental fitness as mentioned above, however, will be a problem: the average age for the outbreak of senile dementia is not growing.

In this Chapter some Finnish and EU statistics will be compared. It should be taken into consideration that EU figures include Finland.



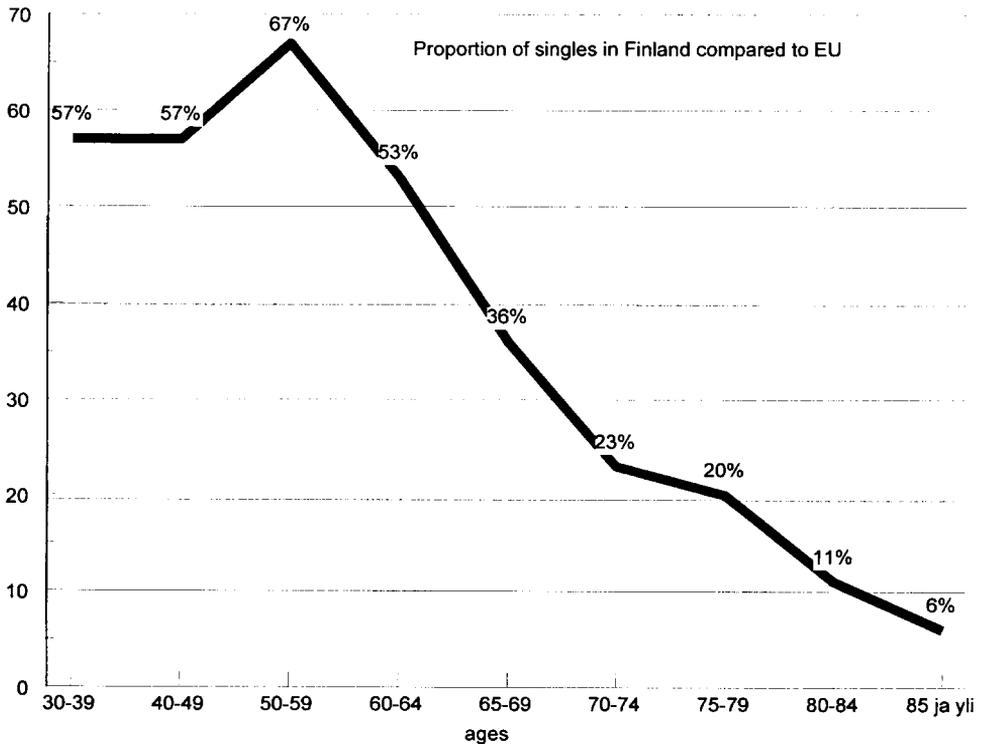
Graph 1. Age distribution in Finland and EU in 1996.

In Finland as well as elsewhere the amount of elderly people shall increase in the following decades. People live longer and simultaneously the large post-war cohorts reach old age.

The difference between Finnish and EU age distribution is in the ratio of post-war cohorts: Finns of age 40-44 are 17% more, ages 45-49 even 27% more and ages 50-54 12% more in Finland than average EU. The amount of young people of 20-29 is on the other hand 13% less than EU.

2.2. The Family Structure of the Population

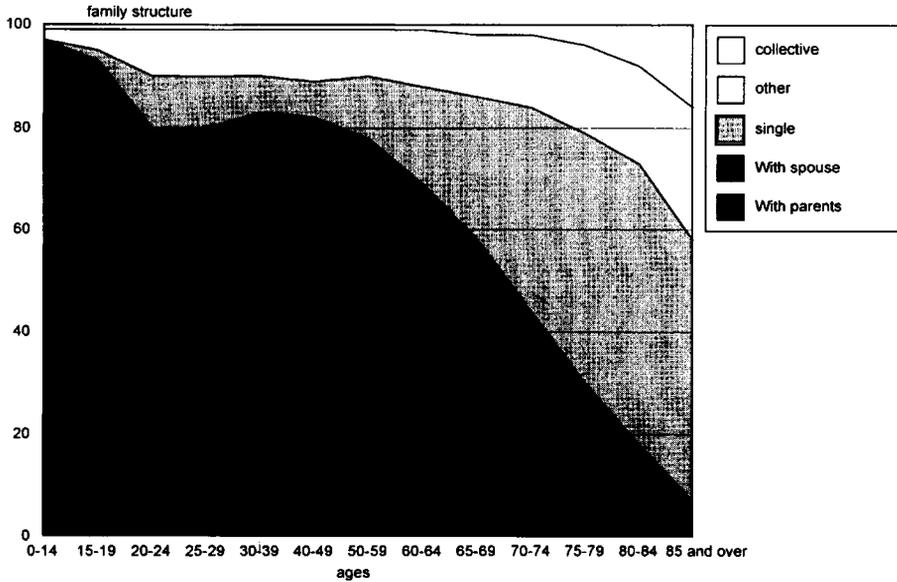
The family structure of Finland is distinctly different from EU. In the Finnish working ages there are definitely more people living alone. In the post-war cohorts there are over 50% more single person households in Finland than in EU. This means that we will have a considerably larger portion of lone old people to take care of.



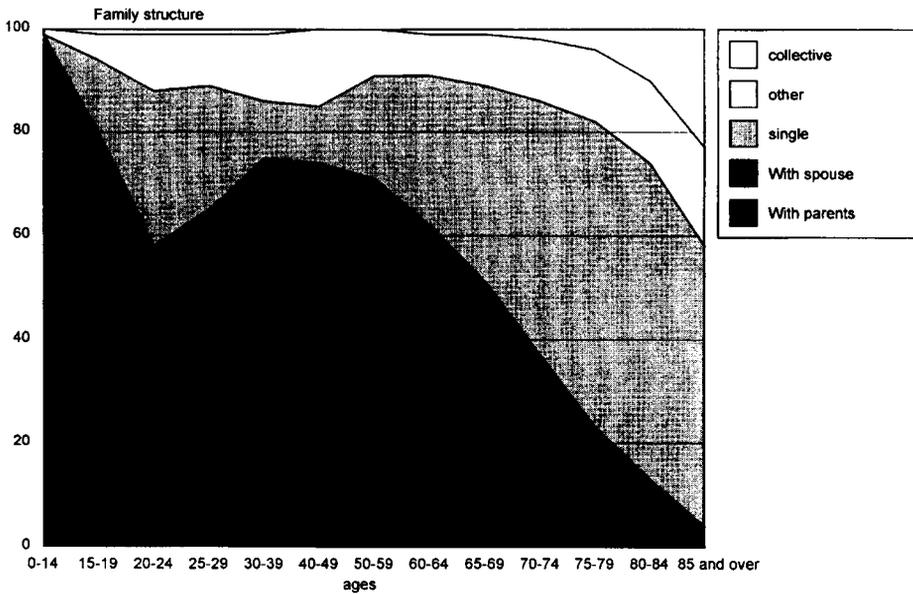
Graph 2. Relative number of Finnish single households compared with EU.

In Finland, young people move away from home earlier than in the EU in average. They may move away already at the age of 15-19 to study because of the distances in Finland. In addition to that, Finnish people stay alone more often and also spend their old age alone more often as described in the following two graphs.

According to the EU standards, we Finns are a very lonely people. Most people live alone some time in their life, as we are also one of the leading nations in divorces with almost 50% more divorces than the EU average and almost half of all marriages ending up in divorce.



Graph 3. Family structure in EU.



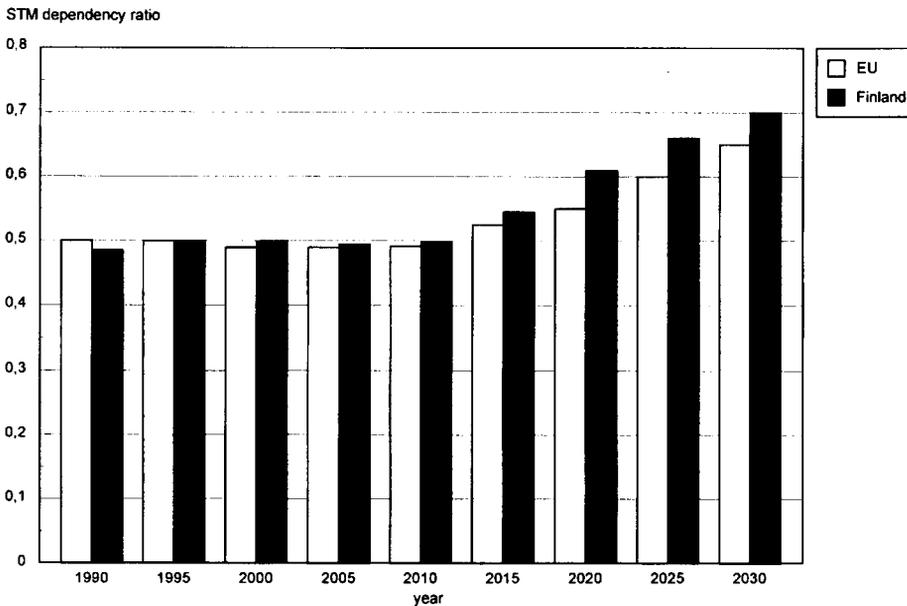
Graph 4. Family structure in Finland.

To solve the long term care problems in Finland, we will have to solve the problems concerning a society of elderly single people in particular.

2.3. Dependency and Economic Dependency

In the year 2050 there will be over 100 million persons of over 65 years of age in the European Union. This will be a significant amount of people, votes and opinions. In many countries the authorities have also come across a decreasing birth rate, which shifts the structure of the population towards old age even more. Two figures describe the ratio of different age groups, namely dependency ratio and economic dependency ratio.

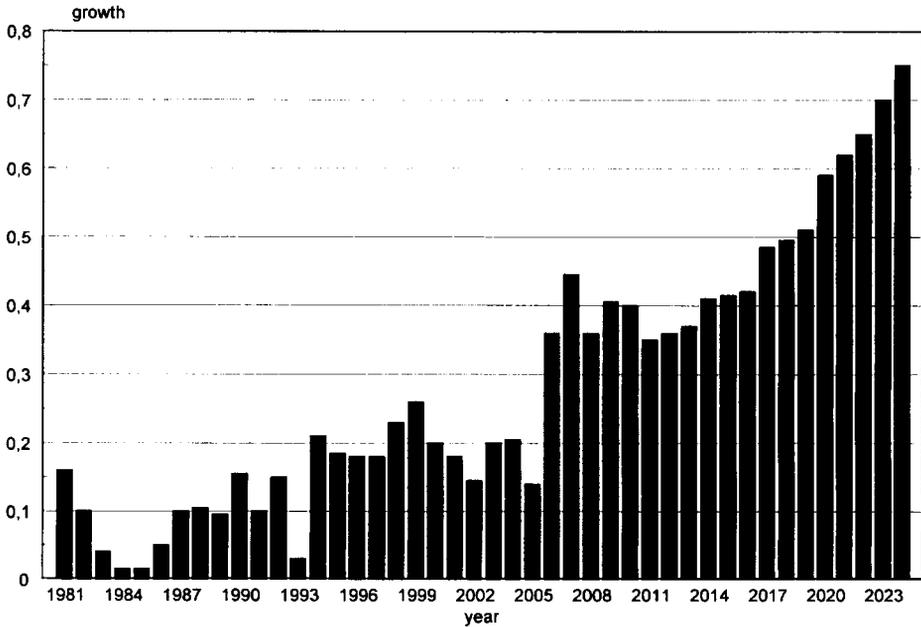
According to the forecast, in 2050 there will be already 700 persons of non-working age, most of these over 65, for every working age population of 1000 persons. This number is now 500 (Graph 7).



Graph 5. Dependency ratio.

The economic dependency ratio has been quite stable, between 1.4 and 1.5. This means that for every working population of 1000 persons there are 1400 - 1500 non-workers such as pensioners, children, students, unemployed, and those drifted away of society. Housewives are included in the number of non-workers, though certainly not as non-workers but as non-paid workers.

All the trends mentioned here are due to the large growth of the old-age cohorts. The problem will be that the ever-decreasing number of working age citizens is supposed to support the ever-growing population of the elderly. The pensions of future pensioners will be bigger than the pensions today, and thus the proportion of the expenses that future pensioners will carry themselves will be larger according to the Finnish income-related tariffs of elderly care. Still the demands for growth in productivity will be substantial for the working population as shown in the graph 6.



Graph 6. Yearly growth in productivity needed to compensate the growth of the number of elderly population.

The family care of an elderly person is mostly the task of a woman, either wife, daughter or daughter-in-law. Finland has, however, the highest proportion of women having a full-time occupation. The number of women working full time is almost 70%, and many of the ones not working are members of the ageing generation. Hence the natural caretaker at home will not exist in the future, even if the old person had children.

2.4. The Finnish Population Density

The population density of Finland is one of the lowest in Europe. The population is also spread very unevenly on the map. There is a continuous movement towards Helsinki and its surroundings from all over Finland. The older generations and the pensioners remain behind.

Table 1. The area, land area and population density of the Finnish municipalities.

Municipality	Area, km ²	Land area, km ²	Population 31.12.1998	Population /land-km ²
Uusimaa	6 767	6 366	1 274 475	200
Itä-Uusimaa	2 823	2 747	88 159	32
Varsinais-Suomi	10 855	10 624	443 050	42
Satakunta	8 746	8 290	240 821	29
Kanta-Häme	5 707	5 204	164 914	32

Pirkanmaa	14 668	12 605	444 505	35
Päijät-Häme	6 257	5 133	197 443	38
Kymenlaakso	5 588	5 106	189 802	37
Etelä-Karjala	7 236	5 674	138 104	24
Etelä-Savo	19 181	14 436	170 348	12
Pohjois-Savo	19 954	16 510	255 234	15
Pohjois-Karjala	21 585	17 782	173 664	10
Keski-Suomi	19 386	16 248	260 135	16
Etelä-Pohjanmaa	13 997	13 458	197 703	15
Pohjanmaa	7 849	7 675	174 099	23
Keski-Pohjanmaa	5 474	5 286	72 094	14
Pohjois-Pohjanmaa	37 120	35 291	360 753	10
Kainuu	24 452	21 567	92 071	4
Lappi	98 946	93 003	196 647	2
Ahvenanmaa	1 552	1 527	25 625	17
Whole country	338 145	304 530	5 159 646	17

2.5. Tax and Social Security

Finland, Sweden and Norway collect the highest taxes, along with the Netherlands and Belgium. In Finland, the marginal tax for a worker with family is 56%. A higher amount can be found only in Denmark (59%) and the Netherlands (61%). With taxation as high as this the citizens will find it hard to accept new expenses, and expenses for elderly care are even harder to accept, because they seem irrelevant and distant to young people. It will be difficult to motivate young adults to save for their old age, which is so far away – not to mention the expenses of the elderly of today.

Still, Finland uses only an average European amount of money for social security. Of this amount the money used on old people is distinctly lower than the European average. Only Spain, Greece, Portugal and Ireland use less than Finland – and in these countries the status of family and family ties are stronger.

2.6. Other Finnish specialities

The Finnish home care system has to take into account certain factors which are mostly unknown or meaningless in other parts of Europe. An elderly Finnish person is accustomed to snow, but the frailty and slowness of old age bring extra risks to his daily errands.

The sauna has an essential role for most Finnish people. Climbing up to the high benches in the sauna to enjoy a good and refreshing *löyly* is not only slow and difficult but also risky. The problem with sauna is that the air is hottest near the ceiling and this necessitates the climb up near the ceiling. There are some modern solutions that enable good *löyly* also in the

lower parts of a sauna. Things like this, essential parts of the Finnish culture, have to be taken into consideration. Shall the ability of going to sauna be considered one of the Activities of Daily living in Finland? It certainly is a part of the washing up procedure for many elderly people.

(*Kiuas* is a kind of an open oven filled with stones, which is heated by wood or electricity and which heats up the sauna usually to 70 – 100 degrees Celsius. *Löyly* is the hot steam that comes out of the *kiuas* when you throw water on the stones of the *kiuas*.)

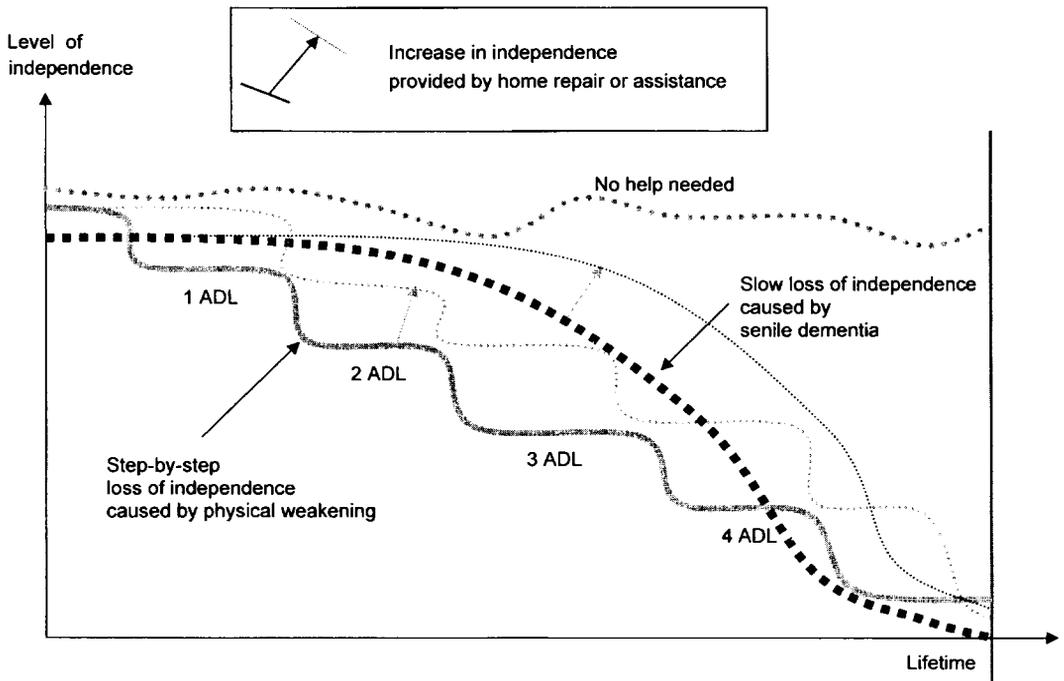
Finnish old people are also accustomed to living alone, often in remote districts. The solution which best respects the values of an old person enables him to continue living in his old, modest house in a distant place, alone, rather than to secure him a place in an elderly home with all the comforts. This is also taken into account, and public means are provided for enabling living at home, for instance, by building indoor toilets and showers by the local authorities.

Hence cultural differences and varying natural conditions require different solutions.

3. When Do We Need Long Term Care Insurance?

3.1. How to Define the Need for Care

The following graph is somewhat unclear, as is the subject it aims to describe. Ageing is a process that is an aggregate of many factors.



Graph 7. Process towards total dependence

With the help of assisting tools, home repair and home care the insured can cope longer without having to turn to society for help. Consequently, his quality of life remains better and the public funds are not needed until at a later stage.

Physical ability is often described with a state graph where each state describes a group of ADLs, activities of daily living. The ADLs measured are usually dressing up, washing up, eating, mobility, and toileting. The insured's ability is measured according to these states, so that he moves from the state of 0 ADLs (no activity problems) to 1 ADL (incapability to perform one ADL), 2 ADLs, and so on. The basic assumption is problematic: the ability to move, for instance, is definitely a very fuzzy concept. It is solely the degree of ability that you can measure factually, starting with 100% ability and ending with 0%, i.e. total disability. However, the physical ability to perform the ADLs is usually calculated according to a state model. This provides claims handling with a basic problem: how to decide the state at which the insured does not perform the ADL he performed yesterday?

The mental state is usually measured according to a continuum of constantly weakening mental capacity. Even then, the insurer has to try to find the point of time at which the entitlement to benefit has arisen while it did not exist the previous day.

The Belgian system of evaluating a claim in the public sector is an extension of the two-state model and involves a certain level of "fuzziness".

3.2. A Flexible Definition of Entitlement to Benefit

The Flemish part of Belgium applies an evaluating system called the Katz scale (*Katzschaal*). Also here the evaluation of the need for care is done according to the ability to perform the ADLs. The scale defines 5 ADLs, and for each of them a level of dependency. The total number of points is given as a sum of the points for the 5 ADLs. The reason for the incapability can be physical or mental. For instance, the person is equally incapable of eating independently if he is too weak to lift the spoon to his mouth or if he is too vague to remember to lift it.

Table 9. The scale and evaluation of ADL.

ADL	Independently	With little help	With a lot of help	Completely dependent
Eating	0	3	6	10
Dressing and undressing	0	3	6	10
Washing	0	3	6	10
Moving	0	3	6	10
Toileting	0	3	6	10

Hence the person may have 0 to 50 points, being totally dependent with 50 points. The scale forms almost a continuum between 0 and 50 points and could be expressed already as a fuzzy concept of dependency as such: the degree the person belongs to the group of completely dependent would be 2 x his points. A continuum like this could as such work also as a basis for the payment of a claim. For example, after 20 points the insured would be entitled to compensations at the amount of his total points divided by 50 and multiplied by the sum insured.

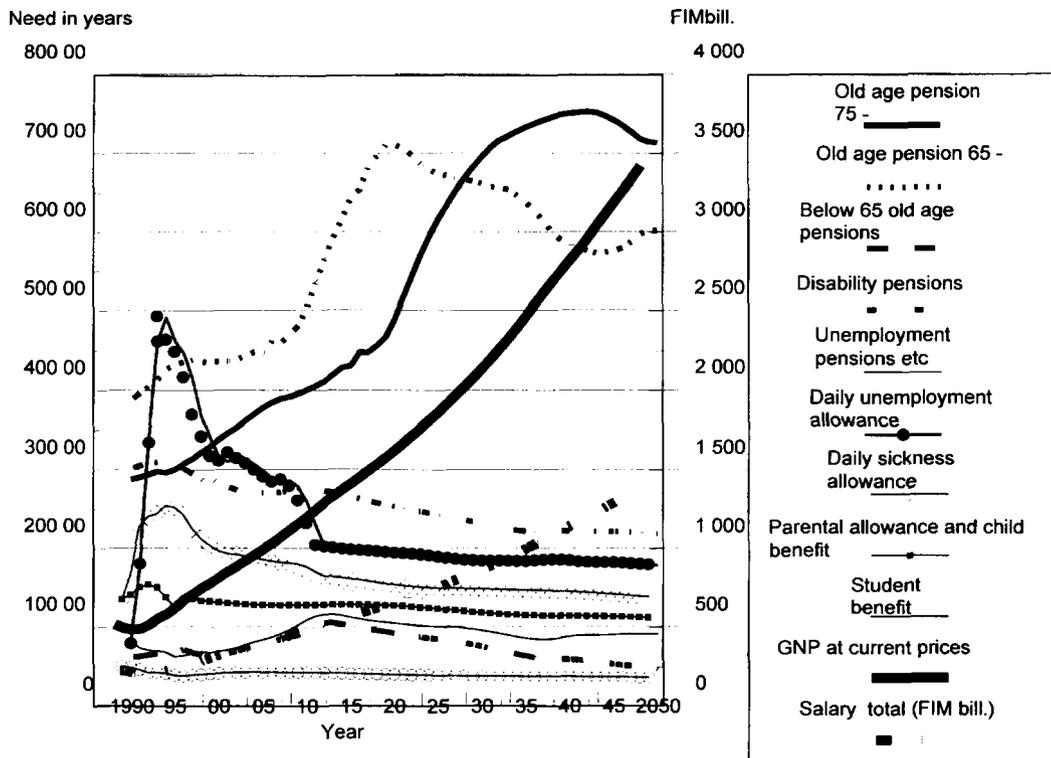
The system in Belgium is a little more liberal: the claim is paid as an annuity according to the following table:

Table 10. The proportion of the total payment.

Katz points	Compensation
0 - 17	0 %
18 - 21	40 %
22 - 29	70 %
30 or more	100 %

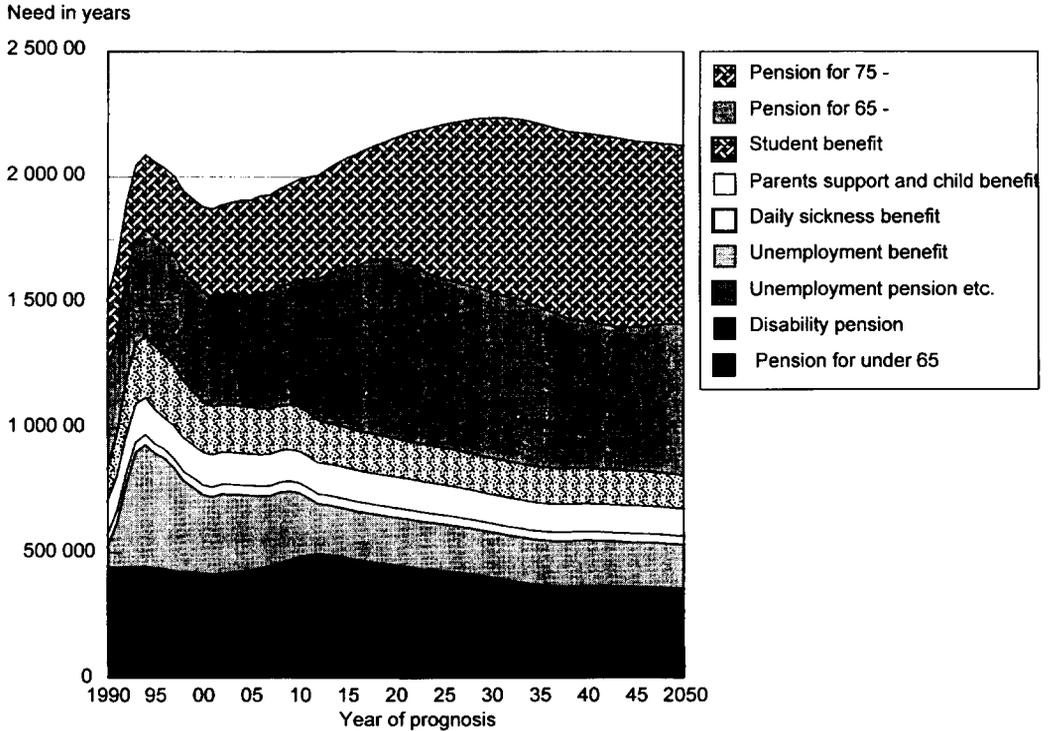
3.3. Does Private Long Term Care Insurance save Public Expenses?

The insurance may postpone the need for nursing home and other heavier forms of care by helping to repair the elderly person’s home to better fit his needs, or by acquiring equipment necessary for mobility – and, of course, by hiring a care person to help at home. A day at an elderly home costs now approximately FIM 400. If two percent of the elderly took an insurance which postponed their need for public services by one year, we would be talking about a substantial sum of money: a population of 20,000 elderly postponing their stay in an elderly home by one year would mean a saving of almost FIM 3 billion (FIM 3,000,000,000) of public expenses. As care at home is not as expensive as in an institution, this would not mean only that amount of money being transferred to private side, but also partially total saving. If the public share were 50%, the public savings would be FIM 1.5 billion. In Finland, the resident of a public nursing home pays up to 80% of his income, or up to the actual costs. Hence the costs of FIM 1.5 billion for the elderly themselves would mean an average pension of FIM 7,500.



Graph 8. Prognosis of certain expenses and the change in the GNP till the year 2050.

The above picture expresses on one axis the growth of the GNP and the expected earned income and on the other axis the change in some expenses. It can be seen that the most significant expenses will be various old-age pensions, especially those of over 75 year-olds. Other classes of expenses are reducing and to some extent compensating the effects of old age. Old age is constantly becoming more and more expensive for the government and will consume a major part of the budget.



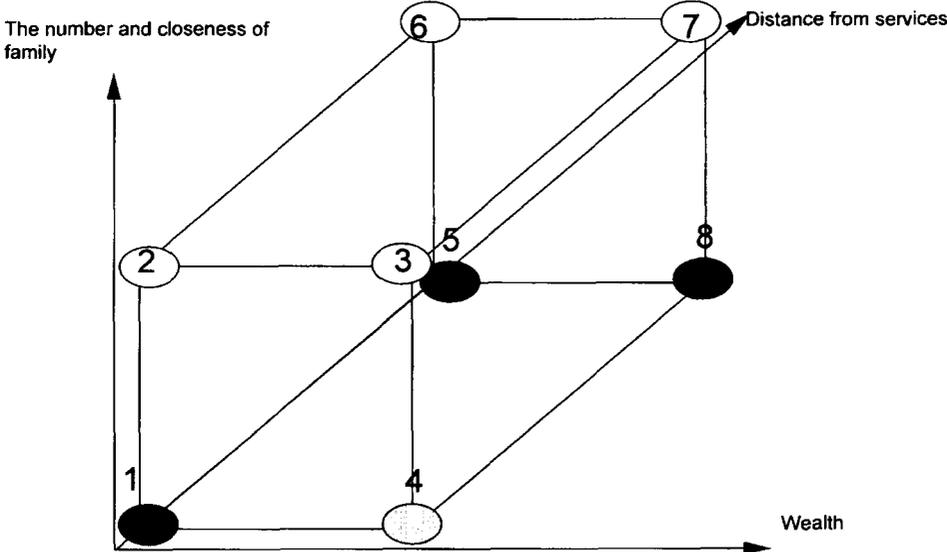
Graph 9. Cumulative graph of certain expenses till the year 2050.

3.4. The three aspects of equality in old age

The following three-dimensional graph is an attempt to describe old age in a slightly wider perspective than usual. The debate on old age, and especially on insuring old age, focuses often on money and on the inequality such an insurance might create: some people can have a safe old age by insuring it with the extra money they have, meanwhile others with less or no means will be entirely dependent on public, probably diminishing welfare – which may even not be kept up to date because of the private alternative available. Hence a private Long Term Care Insurance might be seen to create more inequality. Concerning equality, I find it, however, essential to first stop for a moment at the concept of equality itself. Equality in itself will never be achieved, having so much to do with one's own values, abilities and ambitions. In any case, equality should not be measured in money. Graph 10 describes three dimensions in terms of which people can find themselves in very different situations. Each of these dimensions can in itself be a measure of equality. The best measure, however, is to look at all three simultaneously.

The first dimension is the degree of singleness or loneliness. This axis measures the number of next of kin and the readiness of them to help the old person. High on the axis is the person who has a spouse or children, is on speaking terms with them and lives near them. He will get immediate help whenever he needs it. The horizontal axis describes wealth: the further from the origo, the more property. On the axis going backwards from the graph is the distance from services. The further back, the further also the services are. Equality starts and ends here: the money on your bank account is not enough if you have no-one to notice that you

need help which you could buy with that money. Neither does money help much in the occasion where you are living far away from all services and where even money cannot buy services to your home. The lucky ones by far are those who have someone nearby to care for them. At old age people with modest income but having family around them may consider themselves very lucky.



Graph 10. Who needs Long Term Care Insurance?

We can see that the people who do not really need Long Term Care Insurance are cases 2, 3, 6 and 7 on graph 10. The ones in need of help are 1, 4, 5 and 8. The ones who can afford to buy help are 4, 8, 3 and 7, of whom the needers are only 4 and 8. For case 8 help might not be available, as he lives in a distance from any services. The ones needing public support even if private insurance was launched are 1 and 5. So, equality is hard if not impossible to achieve.

4. Long Term Care Insurance Products in Brief

4.1. Risk or Savings Product?

There are various excellent English texts on LTC products and product development listed on the appendix. The purpose of the Finnish version was to present a Finnish summary on the existing presentations. In this English version there is no need for that.

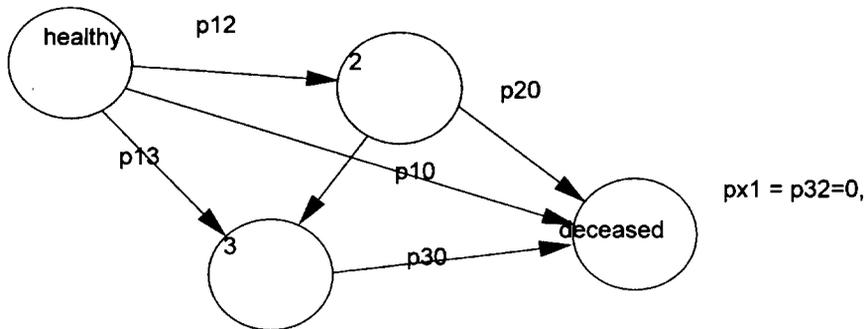
Long term care insurance is sold either as risk products or savings products. So far, risk products seem to be the most common ones. Investment insurance products, however, do exist and will probably be more popular in the future, and more fitting, perhaps, for the Finnish Health Insurance market at present.

4.1.1. Risk Products

Most risk products have level premiums determined by the insured's age at the time of underwriting. The premiums constitute a technical reserve for the customer, and as the risk is the greatest at old age and very small in youth, the premiums can be really moderate if the insurance is taken out when young. Usually the technical reserve has no surrender value. If the customer cancels the policy he loses the money invested in it. Sometimes he may have a right to reduced compensation.

The premium can be based on the integral of the risk function, if known, from the starting age. The cumulated premium can then be divided to the probable years of payment. This division is usually done so that the premiums are level premiums and stay that way with some allowance for inflation. The longer period the insurance is in force, the greater the risk of unpredictable and unaccounted for inflation in claims expenses. Usually, a right to increase premiums periodically, say every 5 years, or inflation protection is included in the terms of Long Term Care Insurance.

The unknown probabilities in the model are a basic rating problem:



Graph 11. ADLs and the transfer probabilities form the usual basis for Long Term Care rating

Normally, the presupposition in rating is that there will be no recovery. This assumption is supported by the experience gained so far. The premiums are usually calculated by using age, sex, type of cover, type of payment, sum insured and payment period.

The long term care insurance premium depends naturally on the variety of coverages, on the number of ADLs needed for a claim, and on the monthly annuity or maximum monthly expenses. There is usually a deductible of approximately three months, plus some service available for the claimant. Using these assumptions a very rough approximation would be that the premium for a level payment risk policy for an annuity of FIM 7,500 would be FIM 4,000 - FIM 6,000 a year, if the insurance is written at the age of 45. If taken at the age of 55, the premiums for the same cover would be FIM 5,000 - FIM 7,000, and for a 65 year-old FIM 9,000 - FIM 12,000 a year.

4.1.2. Long Term Care Savings Insurance

4.1.2.1. Pure Long Term Care Savings Insurance

The model described here is imaginary.

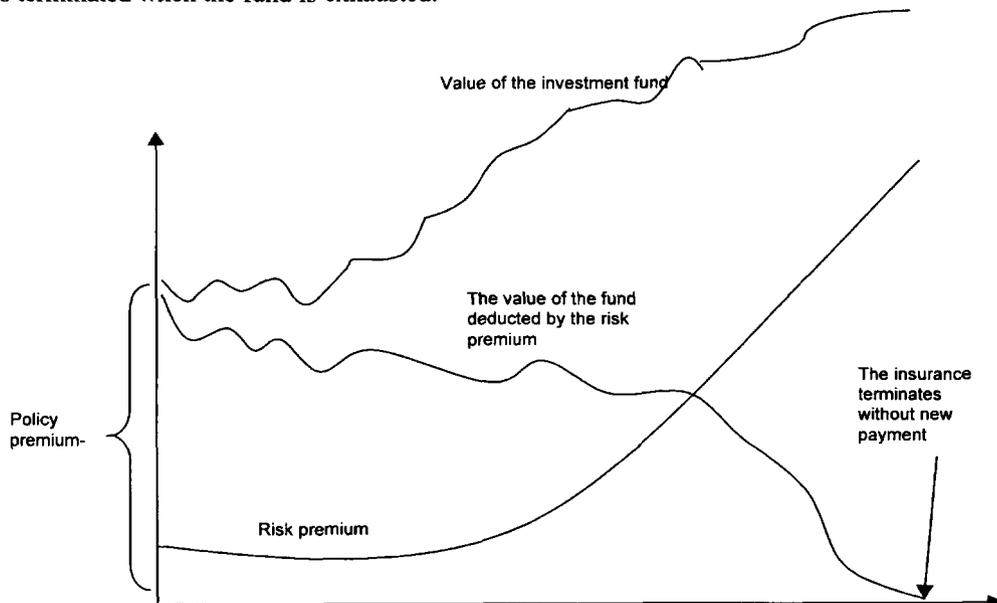
In a pure savings Long Term Care Insurance the customer pays a lump sum to the insurer. His insurance consists only of the fund created by the lump sum, and the insurance has no risk element. Hence the insured has a fund which he can use for the expenses of his old age if he fulfils the conditions included in the terms of the fund. If he dies, the fund will be paid to an agreed person, who can transfer it to cover the expenses of his old age. Such insurance could also be written for a limited period after which the remains of the fund will be returned to the insured, if he is alive. When the fund is used up, the insurance terminates.

In such a model the criteria triggering the payment could be considerably more liberal. On the other hand, as there are a number of other forms of investment available, such insurance would benefit the customer only if it provided some tax benefits or if it secured help and service to the ageing insured.

4.1.2.2. Long Term Care Savings Insurance Including Risk

In unit-linked policies the customer can link the value of his savings to that of an investment fund. From the insurance savings are then deducted the risk premium and other charges. The deduction can be made in two different ways described in the next two graphs.

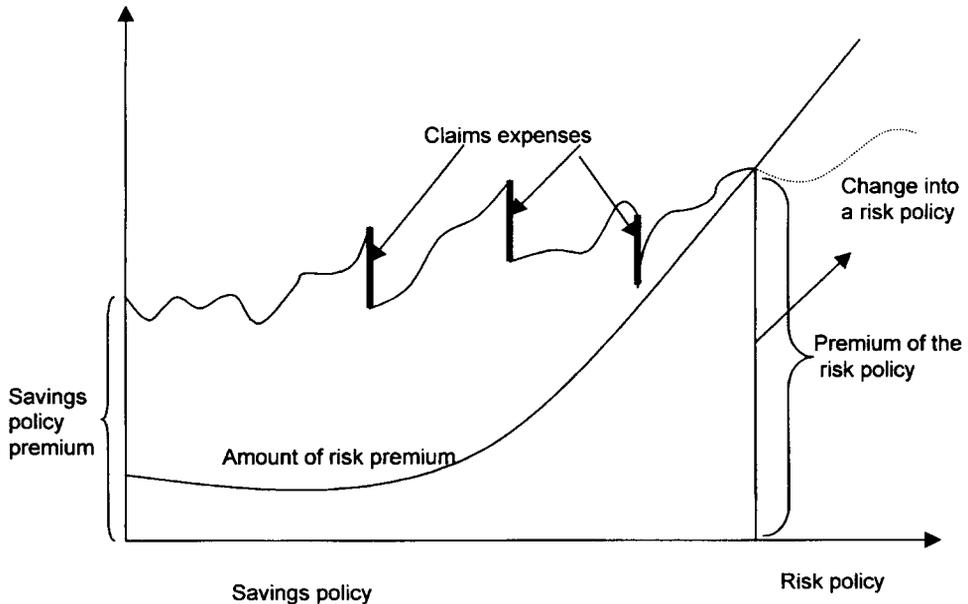
The deduction can be made continuously (Graph 12). Then the risk insurance is in force from the underwriting. In this case the claims expenses are paid from the risk insurance and the risk premium reduces the value of the fund continuously. Without extra funding the insurance is terminated when the fund is exhausted.



Graph 12. Long term care savings insurance including risk, continuous model

On the other hand, the fund can also be used partly as a deductible (Graph 13). In this case the value of the fund must always be greater than the risk premium. If the customer becomes

liable to compensate, compensation is first paid in full from the savings. The fund is hence a deductible, and during this period the risk insurance is not used. The benefit of this model will be that the risk premiums are the smaller the larger the fund. If the value of the fund becomes equal to the risk premium at that moment, the insurance becomes total risk insurance, and the remaining fund is used for the premium. It can remain a savings policy only by making a new deposit to the fund.



Graph 13.

4.2. Funding Long Term Care Insurance with Property

In Finland the elderly do not have to sell their property to pay for the expenses of using public facilities at old age. The salary is used up to 80%, and this may cause situations where the elderly person has to sell his property because of not being able to pay for its expenses. In many other countries he is, however, expected also to use his property.

An agreement can be made to finance a lump sum payment risk policy with the insured's home or other property, so that the insurer is entitled to all or part of the value of the property when the insured is deceased. Some insurance products of this type exist, most often linked to a pension plan. These have been rather unpopular due to the sensitivity of the idea: giving up one's home to an insurance company after having worked a lifetime to get it has a definitely negative sound in it. However, such a solution might be an advantage for single old people, which there will be plenty in Finland in the future. They may have no one to leave their property to, and the right to live at home as long as possible may be worth paying for. In this way a long term care policy may enable the insured's living at home and pay for his home care and home repair, while the insurer will receive as payment the right to the property or part of it after the insured has died.

4.3. How to Sell Long Term Care Insurance?

Insurability depends largely on the risk of antiselection. In standalone solutions for private people, antiselection is very difficult to avoid. Only those who need long term care insurance will buy it. Group solutions are better for the insurer when they can ensure an average or better portfolio. Even better solution is if the premium is paid collectively and hence every member of the group is insured. Compulsory policies are, on the other hand, secure in ascertaining also the people to be insured with low risk. On the other hand, the insurer cannot decline even a clearly high risk. Hence the insurer is open to antiselection and this can cause a serious solvency problem due to the very high expenses possible on Long Term Care Insurance. A compulsory insurance would require, for example, a balancing pool protection for the insurers.

Long Term Care Insurance is, however, mainly sold in Europe to private people as standalone policies. The risk of antiselection is there, but attempts to avoid it are made with precise health declarations or long waiting periods. Long term care business is so new that success remains to be seen in the future decades.

4.4. Long Term Care Insurance in Some Countries

In addition to the European countries visited in connection with this study, namely France, Germany, Great Britain, Belgium and Denmark, also USA, Japan and Israel have interesting long term care insurance markets.

In the USA, long term care insurance is a natural, though still not very popular, extension to private health care. USA launched the first long term care policy in 1974 having now more than 5 million insureds. The yearly growth rate has recently been 22%. Twelve major companies have 80% of the market share, and over 80% of the policies have been sold to private customers of the average age of 68. USA has an extensive range of products.

Japan is in the process of developing the forms of financing elderly care. A social insurance will be launched for the population of over 40 year-olds, paid partly by the employer and partly by the employee. Japan started with long term care life policies in 1985 and long term care non-life policies in 1989, having now some 870,000 life policies and 1 million non-life long term care policies. The public long term care insurance will be launched on April 1, 2000.

Israel started their long term care business in 1989 having internationally the highest long term care insured portion of over 50% of the population. Large group policies have been sold via sickness funds.

Germany started its long term care history in 1985 with life and health care policies. In 1992 a second generation of long term care insurances sold by life companies was introduced, and in 1995 the compulsory long term care insurance. For those above the income level of a compulsory policy an equal voluntary policy is obligatory unless they have no health policy. Hence Germany has a private long term care insurance market of 8 million policies and 412,000 linked additional policies offering more extensive cover. The compulsory policy is funded half by the employer and half by the employee with 1.7% premium of the salary for both. The policy includes also the family.

France has a successful private market with over 560,000 policies, of which 260,000 are private and 300,000 group policies with limited, small coverage. The first policies were

launched in 1985. The two largest insurers who have been very successful in selling to their own customer portfolio dominate the market. The policies have waiting periods of 0-3 years, some inflation coverage and rather limited health declarations. There is some fear of antiselection, but the results remain to be seen in the future decades.

In spite of its vast amount of actuarial and other studies on long term care, long term care insurance has not been a great success in the Great Britain so far. There are 16 products sold by 12 companies, starting from 1991. About 30.000 policies have been sold, 60% of which after 1995. The two major groups are level risk policies and point-of-need policies, which means a lump sum payment to balance the budget once the need for care has already been established. A Royal Commission has been set for and has duly submitted a report on the need for long term care in Great Britain in the future, the consequences of which will remain to be seen. So far to my knowledge the government has not acted upon the report.

The Flemish part of Belgium has launched a new law (*Decreet houdende de organisatie van de zorgverzekering, 30 maart 1999*) concerning the financing of old age, especially the non-medical expenses. According to the law, every inhabitant of the Flemish region belongs to a specific fund (*zorgkass*), which only covers the auxiliary costs of old age living. The insurance companies have a possibility to create such funds and using them as a basis for extra product development. An interesting feature in Belgium has been the compulsory participation of children to the costs of their parents' old age expenses. The new funds and the pool organisation supporting them will not be put into practise until in 2001. This gives the insurance companies good time to develop a product package to support the basic coverage given by the fund.

5. Possible Solutions for Finnish Long Term Care Insurance

The Finnish municipalities have the responsibility for organising care for old people. There is a lot of doubt on how the public sector will be able to fulfil its responsibilities in the future. On the other hand, though, the elderly will in the future be able to better arrange for their own living and care with the help of better pensions and more prosperity. Public and private sources will have to be combined in a way that benefits the elderly population and does not cause unnecessary extra expenses or inequality. This is a task that will have to be tackled in Finland in the course of the process towards launching private long term care insurance.

The following chapters give an overview of the types of compensation and their suitability to Finnish social environment and culture.

5.1. Care at home or in a nursing home

The basis of any long term care insurance solution is the compensation of either home care or nursing home expenses. This can be done in two basic ways, either by monthly annuity not taking into account the actualised expenses, or by compensating the real expenses. The latter, to be safe from uncontrollable inflation, is usually limited to a maximum monthly amount. The negative side of this safety action taken by the insurer is that the uncontrollable part of the expenses will fall on the insured, who may have had full cause to expect the insurance to pay his old age care needs. An inevitable point is, though, that the inflation of the care expenses may not be as rapid if there is no such secure payer as an insurance company. Another natural extension of this type of compensation is its changing into an annuity at a certain, quite old, age. This is the case in the first Danish product, the age limit being as high as 95 or

99. This means that the insured will get an annuity independent of his health situation if he reaches that age. The insurer saves the all the time more probable costs of claims handling.

5.2. Other Forms of Compensation

Home repair costs may be equally important for the insurer as for the insured. With proper renovation the home can be made fit for the living of an ageing person with weakened strength. This may postpone considerably the need for home care or a place in a nursing home. A Finnish feature that will bring an interesting challenge for the insurance companies, if not also a threat of uncontrollable expenses, is the readiness we have for all new technology.

While the most common type of renovation today is removing the bathtub and bringing in a shower with a sitting possibility, future possibilities are vast. Another typical and rather large expense item for people living in two- or three-floor houses is the chair lift. Additionally, already today such innovations as the safety phone, digital diagnostics, telematic means to measure physiology, and safety bracelets exist. There are also electronic fire extinguishers and computer aided medicine suppliers. Internet can be used efficiently to get home help or specific help when needed. When too weak to active social contacts, the Internet and other modern means of communication will be handy for keeping up social life for the future elderly people, already accustomed to electronic communication.

5.3. Service

The claims service is in itself expensive and very personal and takes a lot of time and consideration. The possibility and need for a personal contact and someone to take the health and management of the claimant to heart will be increasingly important in the Finnish society with its lack of natural caretakers from own family.

There are some possibilities of a mutual organisation called the Rehabilitation Centre for the Insurance Companies extending its practise from third party liability and workmen's compensation also to long term care insurance. This is a possibility well worth trying at least in the beginning of long term care insurance with few claims and little experience. This organisation is well equipped to take care of the customer's situation and planning of the future together with the claimant.

Finland has also quite a few rehabilitation centres that were built for those disabled by war. The number of the original customers is rapidly declining, and the centres have mainly taken three courses of survival. Some are specialising in a certain area of medical problems and related rehabilitation. Others sell services to employers offering health and exercise packages for the personnel. The third line of specialisation is the family fun centres with water parks and entertainment. Now a fourth, soon very much asked for opportunity would seem to arise in the elderly care for the claimants, giving them extra time to cope at home, or for those in danger of becoming claimants soon. Compensating such pre-claim care is, on the other hand, a very challenging task from the actuarial point of view, since the expenses might become very difficult to control without a substantial deductible.

The health service enterprises in Finland are coming to the Internet. In the following years their market place in the Internet will give a chance for the insurers to choose local care takers and give also the insured a possibility to view help according to his needs.

6. Conclusion

Long Term Care Insurance has existed already for a relatively long time in Europe, USA and for example Israel, South America and Japan. The products are, however, too new to provide results on the profitability and solvency of the Long Term Care insurance business. Long term commitments to a price level with only limited rights to increase the premiums are obviously a risk taken with as much wisdom and statistics on the premium calculation as is possible to obtain. The success remains to be seen in the next few decades. Should the nursing costs' inflation run higher than expected, either the insurer or the insured suffers: the insurer may – and usually does – protect himself by an upper limit on the monthly annuity or on the monthly costs of a claim. In this case he can also cut the increase in claims expenses. However, the insured will then have to cover the increase in expenses himself. This will end up being a loss also for the insurer, as customers having paid for years for a safe old age and now ending up in non-budgeted extra payments will raise bad will and distrust towards the insurer. On the other hand, if the insurer does not limit his payments, with an increased and unprotected inflation he will inevitably face solvency problems. Reinsurance agreements will then define who will pay the extra costs for the inflation, the insurer or the reinsurer. This would probably also mean an existing portfolio of future claimants with inadequate technical reserves.

So far, the most successful products in Europe would seem to be risk products. There are savings products, however, and their proportion may be larger in the future. Due to the market situation in Finland, the savings products will be the most probable way to proceed. We do not have a private health insurance business to the extent it exists in some countries, due to our high level of public health service. Hence introducing a risk product for the old age would be difficult: we have not seen it necessary to insure our health, even though the public health system is declining. It will take a lot of convincing to have people believe that they need policies to cover their old age costs, and even more, that they should take those policies already now and not at the threshold of old age. Also, the Finnish life insurance companies seem to have their focus rather in people's savings than their health. The non-life insurance companies, on the other hand, have traditionally two strong areas of premium income: namely workmen's compensation and motor insurance including third party liability and voluntary motor insurance. Health, although non-life insurance according to the EU insurance classes, is not a major source of premium income for non-life companies.

The health insurance business in Finland also taught the insurance companies a lesson in the 1980's which is hard to forget: the companies lost tens if not hundreds of millions of Finnish marks in children's health insurance which had no deductibles and little or no inflation protection. These insurances for their part contributed to the birth of several private medical centres with quick response, excellent service – and increased premiums. The result can be seen as a very quiet health insurance market and very suspicious insurers in Finland. To this area it will understandably be difficult to introduce a long term care insurance product with a lot of responsibility and little knowledge of the risk and inflation in the years to come. The same risk of inflation is also visible as we have only a very small market of private nurses or professional home carers, most of whom obtain their living from the privatisation of the municipal health care. Should there open up a possibility of a new market paid by the insurance companies, the risk for the price inflation would again be obvious. And that is something the companies will want to avoid.

It would seem that Long Term Care Insurance is needed also in Finland as the proportion and number of elderly people is increasing and as people more demanding and more conscious of their rights are growing old. The important reason for the need of Long Term Care Insurance is loneliness. A steadily increasing number of old people are childless, divorced or both, and if they have children, they have become distant due to remarriages, geographical distance or the more and more demanding occupations of today. There will be no one to care for those old people, and there will be no next of kin to plan their elderly care. Buying services directly is always possible, but may be a laborious task for an elderly who is growing weak. The insurance will and should provide means for both obtaining easily the appropriate care and budgeting for it in time.

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