Long-term Care at a crossroads: delivery of adequate protection to the wider public

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1 Introduction

Long-term care (LTC) insurance is a product which protects insureds against future costs to be incurred should LTC be needed. While private LTC protection has existed for several decades, it still is a fairly new product concept since it has evolved through various product development phases. In many countries, it is recognised as a much needed product which supplements the protection provided by the government's safety net. Nevertheless, the commercial success of private LTC insurance has been far behind expectations.

LTC insurance schemes have not been the primary focus of governments and insurance companies in Asia until recently. It has been common practice in most Asian countries to grant LTC benefits on "as needed" basis under the welfare system, if at all. In some instances, LTC expenses have been shifted to the health insurance system. Japan, for example, has historically seen very long hospitalisation stays among the elderly population:

Table 1 Average length of stay in hospital of elderly males in Japan[1]

Age group	1996	1993	1990	Average
65 - 69	48.3	51.3	57.9	52.5
70 - 74	49.1	52.8	60.5	54.1
75 - 79	54.0	59.6	70.6	61.4
80 - 84	63.1	67.3	83.9	71.4
85+	77.7	89.1	101.3	89.4

While the average length of stay has moderated over the years, it is understood that these long hospitalisation stays were mainly caused by elderly people who could not be cared for at other care institutions or at home, and who were thus left in the care of hospitals.

In this paper, we will analyse the extent to which the need for LTC protection exists in Asia. For this purpose, we will examine in detail the demographic, social and economic changes underway in Asian countries.

We will then look at three different approaches of countries to address the need for LTC protection for their citizens, including two Asian countries and the U.S. We will also study the development of private LTC in Korea as an example for the integration of private and public LTC protection.

Finally, we will address failure and success factors for offering private LTC protection.

2 The needs for long term care protection

It is well documented that substantial demographic, social and economic changes that may affect the need for LTC have happened in the developed world over the past decades. Terms such as "Grey Revolution" or “Silver Tsunami” and increased participation of women in the workforce are closely linked to these developments.

We will analyse in this section to which extent such changes can also be observed in Asian countries and the influence these changes may have on the care of elderly people.

2.1 Demographic changes

Life expectancy has increased by about 30% - 75% over the last 50 years in many Asian countries. The gap in life expectancy as compared to the United States has narrowed significantly over this period.

Table 2: Life expectancy in selected countries (medium variant)[2]

Country	Life Expectancy			Increase in Life Expectancy	Gap in Life Expectancy compared to U.S.		
	1950-1955	2005-2010	2050-2055	over past 55 years	1950-1955	2005-2010	2050-2055
China	44.6	72.7	79.7	63%	-24.0	-5.3	-3.8
Hong Kong	63.2	81.6	87.7	29%	-5.5	3.6	4.1
India	37.9	64.2	74.4	69%	-30.7	-13.8	-9.1
Indonesia	38.8	67.9	78.2	75%	-29.8	-10.1	-5.3
Japan	62.2	82.7	87.9	33%	-6.5	4.8	4.3
Republic of Korea	47.9	80.0	85.1	67%	-20.7	2.0	1.5
Malaysia	55.4	73.4	80.3	32%	-13.2	-4.6	-3.3
Philippines	55.4	67.8	77.1	22%	-13.2	-10.2	-6.5
Singapore	60.2	80.6	85.7	34%	-8.4	2.6	2.1
Thailand	50.7	73.6	80.1	45%	-17.9	-4.4	-3.5
Germany	67.5	79.8	85.4	18%			
U.S.	68.6	78.0	83.6	14%			

The countries can be categorised into a group of countries which have closed the gap to western countries by 2010, such as Hong Kong, Japan, Korea and Singapore, and a second group of countries which are still trailing the improvements in life expectancy observed in western countries, e.g., India, Indonesia, Malaysia, Philippines and Thailand. Still, even countries which are trailing the improvements in life expectancy observed in western countries have already reduced the gap to a large extent. It is expected that life expectancy will continue to increase in the future, although at a reduced pace.

The Fertility Rates, i.e., the number of children a woman would have throughout her life, have declined in many Asian countries by 60% - 80% over the past 55 years. Today, the Fertility Rate has, with a few exceptions, reached levels comparable with those experienced in western countries.

Table 3: Total fertility rate (children per woman) in selected countries (medium variant)[2]

Country	1950-1955	2005-2010	2050-2055	Decrease over last 55 years
China	6.11	1.64	1.81	73%
Hong Kong	4.44	0.99	1.80	78%
India	5.90	2.73	1.84	54%
Indonesia	5.49	2.19	1.73	60%
Japan	3.00	1.32	1.87	56%
Republic of Korea	5.05	1.29	1.87	75%
Malaysia	6.23	2.72	1.93	56%
Philippines	7.42	3.27	2.06	56%
Singapore	6.61	1.25	1.87	81%
Thailand	6.14	1.63	1.75	73%
Germany	2.16	1.36	1.90	37%
U.S.	3.45	2.07	2.09	40%

The Net Reproduction Rate (NRR), i.e., the average number of surviving daughters born per woman during her lifetime, has over the last 55 years dropped in excess of 50% and reached a level below the value of 1 in many Asian countries. It is expected according to a medium variant projection that the NRR will stay below the value of 1 and not return to historical levels in the foreseeable future.

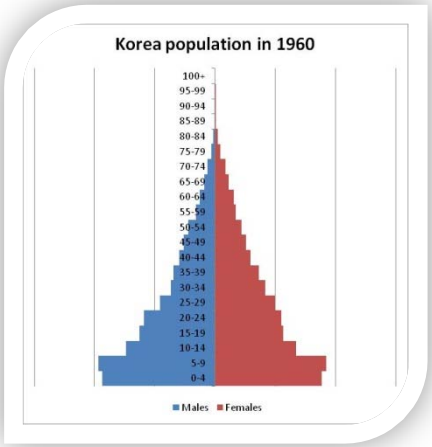
Table 4: Net reproduction rate (surviving daughters per woman) in selected countries (medium variant)[2]

Country	1950-1955	2005-2010	2050-2055	Decrease over last 55 years
China	1.99	0.71	0.85	64%
Hong Kong	1.92	0.47	0.87	75%
India	1.65	1.17	0.84	29%
Indonesia	1.59	1.01	0.82	36%
Japan	1.28	0.64	0.91	50%
Republic of Korea	1.76	0.61	0.90	65%
Malaysia	2.47	1.30	0.93	48%
Philippines	2.85	1.52	0.98	47%
Singapore	2.82	0.60	0.90	79%
Thailand	2.18	0.77	0.84	65%
Germany	0.85	0.65	0.92	23%
U.S.	1.60	1.00	1.01	38%

In countries where the NRR has fallen below the value of 1, the cohort of women cannot be fully replaced by a new generation.

Combining the effects of increasing longevity and reduced fertility rates, it is expected that many Asian countries will experience changes in the population pyramids which are already being observed in western societies. The following charts show a 50-year projection of the populations of Korea and India. The Korean population still has a small cohort of elderly people in 2010, but it is projected that the elderly will make up a clear majority of the Korean population by 2060. Even the population of India, which still displays today the traditional shape of a population pyramid, is projected to experience a substantial aging of its population over time.

Chart 1: Population pyramids in the Republic of Korea and India, 19602



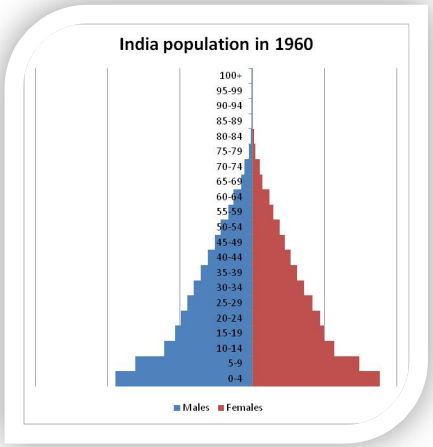
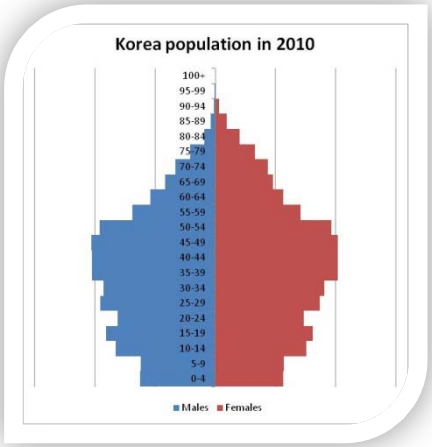


Chart 2: Population pyramids in the Republic of Korea and India, 20102



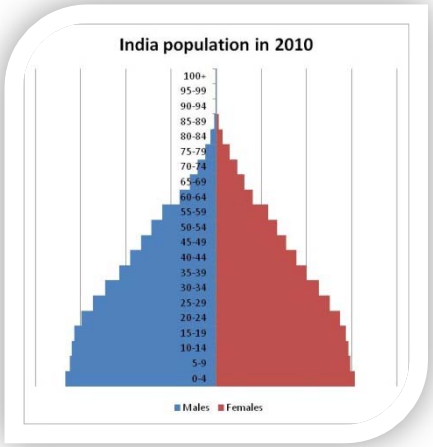
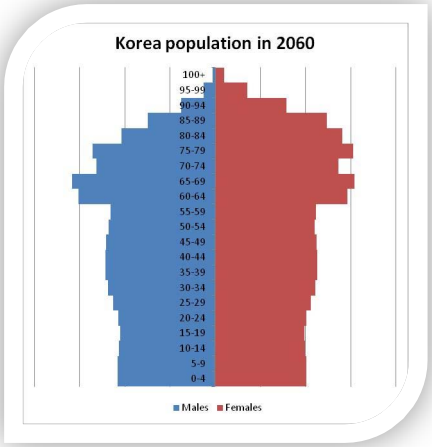
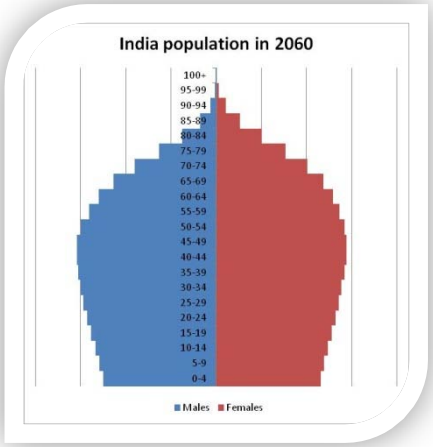


Chart 3: Population pyramids in the Republic of Korea and India, 20602





The aged-dependency ratio, i.e., the ratio of the number of elderly lives (aged 65 and above) to the working population (aged 15 – 64) has consequently increased markedly over the past 50 years.

Table 5: Aged-dependency ratio in selected countries (medium variant)[2]

Country	1960	2010	2060
China	7.1%	11.3%	51.8%
Hong Kong	4.9%	16.8%	58.8%
India	5.4%	7.6%	25.4%
Indonesia	6.3%	8.2%	36.1%
Japan	8.9%	35.5%	68.6%
Republic of Korea	6.7%	15.4%	64.3%
Malaysia	6.7%	7.4%	27.5%
Philippines	6.2%	6.0%	20.7%
Singapore	3.7%	12.2%	61.3%
Thailand	6.0%	12.6%	46.4%
Germany	17.1%	30.8%	55.6%
U.S.	15.3%	19.5%	36.8%

Many countries will see an aged-dependency ratio in the order of 50% and over in the future, i.e., two or less people in working age will have to support one elderly person. Even countries with a more “healthy” population pyramid will see aged-dependency ratios which are in line with the situation observed in the United States today.

The longer projected life expectancy and the trend towards an inversion of population pyramids mean that the number of elderly people who may need care will increase significantly. At the same time, it is likely that the required period of care for elderly people will lengthen due to future medical advances that extend longevity. The demand for care providers and facilities is hence expected to increase and the burden for families who prefer to care at home will become more severe as the already stretched and limited resources will have to care for a growing elderly population and for a longer period of time.

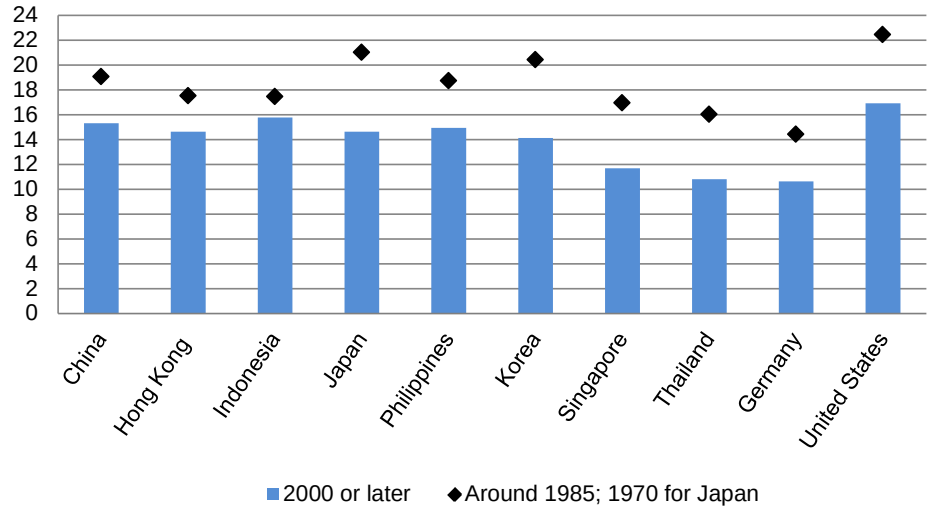
The large increase in the aged-dependency casts doubts on the sustainability of public LTC schemes which are based on a pay-as-you-go system or which are tax funded as fewer working-age lives will have to bear the significantly increased cost of care.

2.2 Social changes

Changes in the social structure can be observed in many western countries. The most important indicators are reduced marriage rates, increasing divorce rates and declining household sizes.

Significant changes in the number and characteristics of marriages can also be observed in Asian countries. Marriage rates have dropped in double-digit percentages in most countries over the last decades:

Chart 4: Annual number of marriages per 1,000 population in age range 20 - 49[3]



The average age of the first marriage has also been increasing, for example, by about 1.7 years and 2.4 years over the past 10 years in Japan and Korea, respectively[4].

At the same time, divorce rates have more than doubled in many Asian countries over the last decades:

Table 6: Annual number of divorces per 1,000 population[3]

Country	Around 1970	Around 1985	Around 1995	2000 or later	Increase over last 30 - 40 years
China	0.29	0.43	0.87	1.46	398%
Hong Kong		0.79	1.53	2.54	221%
Indonesia	0.77	1.00	0.56	0.66	-14%
Japan	0.93	1.38	1.58	2.04	120%
Korea	0.47	0.92	1.53	2.60	449%
Singapore	0.62	0.75	1.17	1.51	146%
Thailand	0.45	0.59	0.93	1.44	218%
Germany	1.34	2.31	2.07	2.32	73%
U.S.	3.48	5.00	4.39	3.70	6%

Consequently, the average household size has declined by some 20% - 30% in many Asian countries. It is still higher than the average household size in most western countries, such as Germany and the United States, which have on average a household size around 2.0 to 2.5.

Table 7: Average household size[5]

Country	Around 1970	Around 1980	Around 1990	Early or mid-2000s
Hong Kong	4.5	3.7	3.4	2.9
India		5.5	5.5	5.3
Japan	3.4	3.2	3.0	2.5
Malaysia		5.1	4.9	4.3
Philippines		5.9	5.3	5.0
Singapore	5.3	4.7	4.2	3.5
Korea	5.2	4.5	3.7	3.0
Germany	2.6	2.4	2.3	2.1
U.S.	3.1	2.7	2.6	2.6

While the labour participation rates of women are largely stable, a moderate increase continues to be seen around the world in recent years.

Table 8: Labour participation rate, female (% of female population ages 15+)[6]

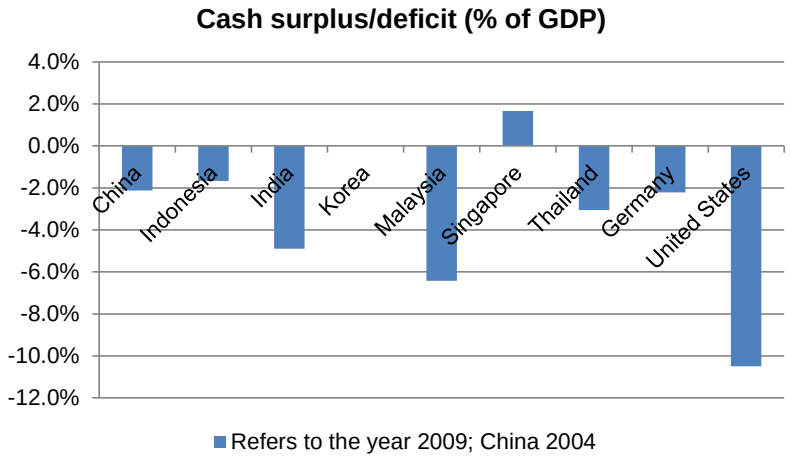
Country	1980	1990	2000	2009
China	71.0%	73.0%	70.9%	67.4%
Hong Kong	45.7%	47.2%	49.5%	52.2%
India	32.6%	34.0%	33.0%	32.8%
Indonesia	44.0%	50.3%	50.6%	52.0%
Japan	47.6%	50.1%	49.2%	47.9%
Korea	43.6%	47.1%	48.9%	50.1%
Malaysia	41.4%	43.0%	44.3%	44.4%
Philippines	50.1%	47.5%	48.6%	49.2%
Singapore	44.7%	50.7%	52.3%	53.7%
Thailand	75.5%	75.1%	66.1%	65.5%
Germany	40.7%	45.2%	49.1%	53.1%
U.S.	51.1%	56.9%	59.5%	58.4%

In Asia, it has traditionally been the obligation of the spouse of the oldest son to provide care for the parents. But a growing trend towards households with only the core family, i.e., spouses and dependent children, can also be observed in Asia. Many elderly are not living with their adult children anymore. Further, reducing marriage rates and increasing divorce rates also impact the traditional solidarity observed in Asian families. It will hence be very difficult in Asian countries to continue caring for the elderly in the traditional family setting.

2.3 Economic changes

Social security systems and welfare safety net programmes constitute a significant financial burden for almost all countries. These budget items have often been disproportionately impacted, particularly during difficult economic times. Indeed, negative budget balances and mounting government debts can be observed in many Asian countries[6]:

Chart 5: Public health expenditure and government cash surplus / deficit (% of GDP)[7]



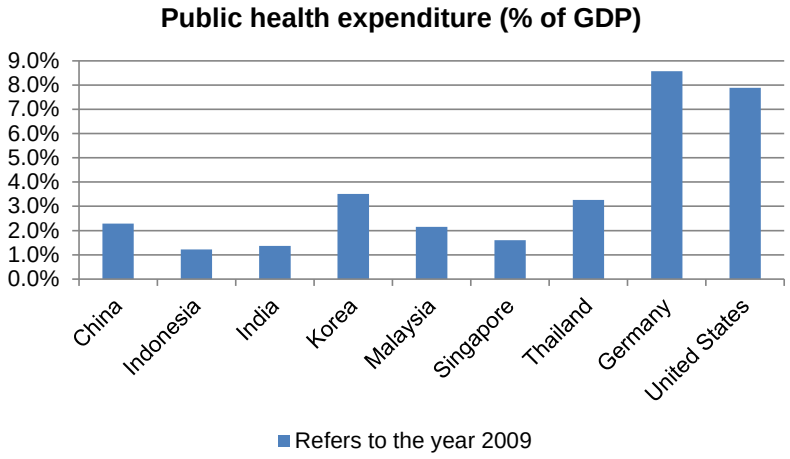
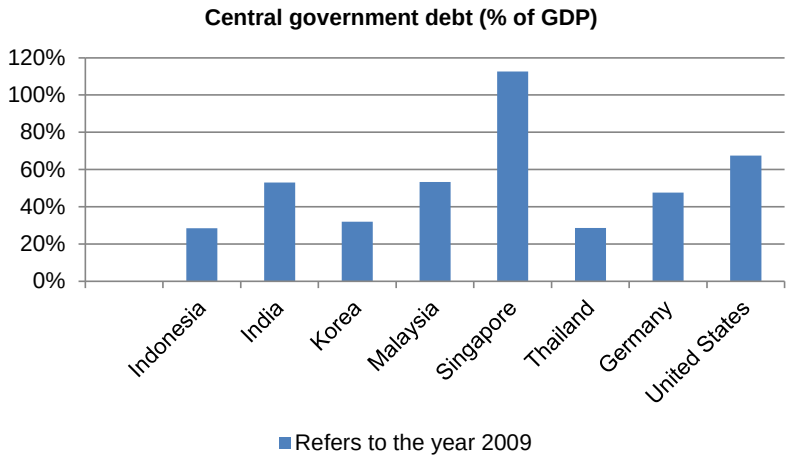


Chart 6: Central government debt (% of GDP)[7]



Under these economic conditions it seems unlikely that the scope of social security and safety net systems, including LTC, will be expanded to any significant degree, or that the state will be able to provide more comprehensive cover for the elderly. It is more likely – and this seems to be in line with the expectations of the vast majority of citizens – that

governments' provisions will decline in the future and that citizens will be required to seek more private provisions.

2.4 Conclusion

The Asian demographical, social changes, and economic development trends mirror developments in western countries, and it is not anticipated that these trends will reverse in the future.

Many Asian populations will consequently experience a situation in which the percentage of elderly persons living with or supported by their children will decrease, while the share of elderly people without children upon whom they can rely in their golden years will increase. Rising divorce rates will further increase the proportion of people who live alone and who will eventually need third-party care.

It seems likely that the traditional definition of filial piety in Asian countries, i.e., care for the elderly being the family's responsibility, will have to be reconsidered. Therefore, a rapidly increasing demand for LTC protection is expected in most Asian countries in the near future.

3 Social security systems

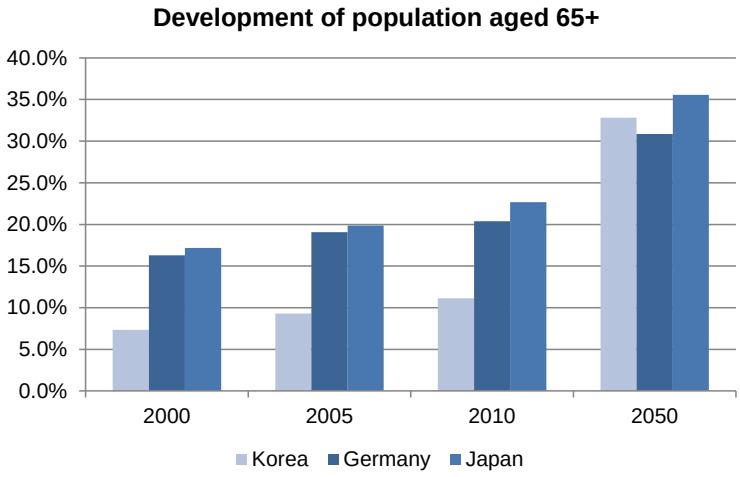
We will look in this section at three different approaches taken by governments to address care needs of their populations:

- the universal LTC insurance program introduced in Korea,
- the public-private LTC scheme introduced in Singapore where private insurers are an integral part of the system, and
- the system in the United States which more heavily relies on the private sector to finance care.

3.1 South Korea

Korea, with a current population of 49 million, is a country with a relatively low proportion of elderly population: In 2010 only about 11% were aged 65 and over, compared with over 20% in Germany and about 23% in Japan. On the other hand, Korea will experience an unprecedented aging of its population: The proportion of the elderly population aged 65 and over is projected to increase to 32.8% in the year 2050.

Chart 7: Development of the elderly population aged 65 and over from 2000 to 20502



Korea's growth in the proportion of the elderly population is projected to be well above both Germany and Japan. For example, the proportion of elderly in Japan and Germany is projected to double within 40 years from the introduction of their public LTC systems whereas the proportion of elderly in Korea is projected to triple during this period. Korea is hence more likely to consider potential adjustments to its elderly support systems in the coming years than Japan and Germany.

Korea is embedded in a tradition of filial piety that perpetuates family-centred elderly care. Approximately 2.1% of Korea's population over the age of 65 received care at home whilst only 1.1% of this population received LTC in an institution in 2009[8]. The role of family caregiver has traditionally been fulfilled by women. This practice has been in steady decline over the years because more women are participating in the workforce in Korea today to supplement the family income, and because later-age marriages, higher divorce rates and

lower fertility rates cause traditional extended families to diminish as discussed in Section 2. It is expected that the proportion of people who live alone and require third-party care will continue to increase in the future.

Only 2.8% of the Korean population aged over 65 years received public LTC benefits in 2008. This contrast with 13.5% of the Japanese population aged over 65 years which received such benefits[9]. The lack of care facilities is a key driver for this different public LTC benefits take-up rate.

In response to the increasing demand for the availability and access to elderly care, Korea implemented a universal, comprehensive LTC insurance program in the year 2008. It is expected that the introduction of the public LTC scheme will result in an increase of care facilities in Korea. For example, the number of home-visit LTC services increased by about 63% and the number of residences providing LTC assistance increased by about 19% within 2 years from the introduction of the public LTC system in Japan[10].

In most aspects, the public LTC insurance scheme in Korea can be seen as a hybrid of the German and Japanese approaches. However, the Korean program is different in its centralized administration, and uniform contributions and benefits that are founded on its single-payer health insurance system.

3.1.1 LTC Providers

Although the number of LTC providers (of which most if not all are private) has increased over the years, availability and access continue to be a persistent problem. As of 2008, there were 1,530 LTC institutions with 64,671 beds, covering 1.3% of those aged 65 and over. Additionally, there were 8,011 home health providers, which were estimated to cover 2.2% of the elderly[11].

On the other hand, it is estimated that about 32% of the elderly population of Koreans aged 65 and over have limitations with Activities of Daily Life (ADL) such as dressing, bathing, toileting, shopping, preparing food, house-keeping, doing laundry, etc., and who would typically need care in view of their limitations. In 1998, it has been estimated that about 19% of elderly Koreans are in potential need of LTC[12].

While the concern with insufficient LTC providers is recognised, Korea neither lost sight of the quality of care, nor does Korea intend to lessen the barrier of providers' entry through sacrificed quality. In order to qualify as an LTC provider in Korea, the caregiver must complete 240 hours of training and pass a national qualification exam as was introduced in 2010. The LTC institutions and provider organizations must also comply with the minimum staff-user ratio defined by the LTC insurance law.

Under the current social LTC insurance program, providers are paid on a fee-for-service basis, wherein a provider calculates the total expense (based on an established cost calculation method) and submits reimbursement request to the National Health Insurance Corporation (NHIC). The NHIC reviews the requests and processes the payments for valid charges.

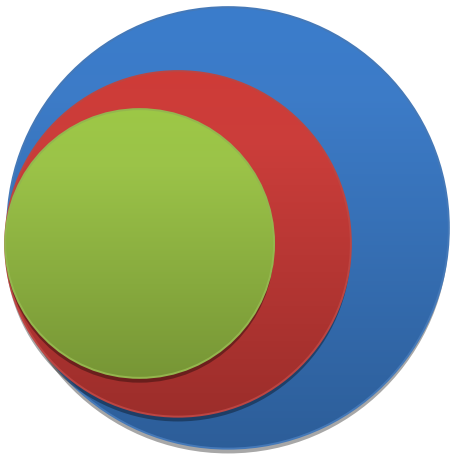
3.1.2 Insuring Entity

The Korean LTC insurance program is insured by the NHIC, which is also the single-payer of health insurance.

3.1.3 Eligibility

Korea provides LTC benefits to those aged 65 and over and to individuals with geriatric diseases regardless of age.

Chart 8: Applicants and Beneficiaries Eligible for LTC Benefits, Korea[13]



- **Target (Whole Population)**
  - National Health Insurance Subscriber
  - Medical Aid Beneficiaries
- **Population qualified for coverage**
  - Senior citizens aged at least 65 years
  - Citizens younger than 65 years with geriatric diseases
- **Population qualified to receive benefits**
  - Citizens who got ratings of “Long-Term Care” since they are judged to have difficulty taking care of themselves for a period of at least 6 months

The eligibility and level of LTC need are determined by an appointed committee, consisting of doctors, nurses, etc., followed by a review of a questionnaire and assessment completed by the local NHIC agents. The assessment criteria include ADLs, age and disabilities/health conditions:

Table 9: Symptoms by grade in the Korean public LTC insurance program[14]

	Care Grade 1 (Severest)	Care Grade 2 (Severe)	Care Grade 3 (Moderate)
Symptoms	• The patient remains lying down all day long and cannot move independently. • The patient needs total help from other persons in daily activities such as eating, toileting and wearing clothing.	• The patient uses wheelchairs but cannot keep sitting posture. • The patient needs total help from other persons in daily activities such as eating, toileting and wearing clothing. • The patient in many cases spends most of the time lying on the bed.	• The patient needs partial help from other persons in daily activities such as eating, toileting and wearing clothing. • The patient can go out only with the help of other persons.
Results of examination	The patient needs total help in more than 6 items of ADL including the changing of body position, eating or sitting down.	The patient needs help in more than 5 items of ADL such as eating, sitting down, washing face or brushing teeth.	The patient needs partial help for 3-5 items of ADL in brushing teeth, washing face, etc.

An applicant can achieve a maximum score of 100 on the questionnaire, and a score of 55 and over qualifies the applicant for LTC benefits.

Grade	Grading Criteria
1	Score 95 or more points
2	Score 75 or more points but less than 95 points
3	Score 55 or more points but less than 75 points

3.1.4 Benefits

The LTC insurance in Korea complements the national health insurance coverage, and it covers services that support physical and housework activities for beneficiaries requiring LTC (institutional and home health). The insurance primarily provides service benefits (such as institutional care, ADL assistance, day and night care, short-term respite care, etc.), and cash benefits are only provided in exceptional cases such as when no providers are available in the region. Cash benefits are less than benefits in kind and amount to KRW 150,000 per month (or about US$ 130)[15] .

The effective LTC insurance eligibility period is one year from the approval date. However, if a decision is made on the same grade for three or more consecutive times, the effective period shall be two years for that individual.

3.1.5 Financing

Korea's LTC insurance is not a pure social insurance system. The program is funded by a combination of contributions paid by the insured, government subsidies, and co-payments paid by the beneficiaries. The funding is primarily contributions-based with limited government subsidies.

This public financing model was built on the existing vehicle established for funding other Korean welfare programs (such as health insurance, pension, unemployment insurance, and workplace injury). Using the same financing model allows the Korean government to leverage its existing NHIC system and provides operational efficiencies[11].

The LTC insurance contribution is paid by the working-age population and is based on a fixed percentage of health insurance contribution. In 2011, the health insurance contribution was set at 5.33% of wages, 6.56% of which went towards LTC – the two contributions are collected together[16]. Overall, the financing consists of government subsidy of 20%, co-payment of 15% (home health) or 20% (institutional care), and contribution of 60-65%.

3.1.6 Cross-National Diffusion in Social LTC Insurance

As alluded to earlier, Korea has applied learning and experience from Japan and Germany in the creation of the social LTC insurance program as enacted in 2008. Many similarities can be found between the Korean and the Japanese and German programs[17].

Similarities to Japan	Similarities to Germany
• Restricts benefits to people aged 65 and over and those with geriatric diseases regardless of age (but not only such people aged 40 and over as in Japan) • Financed by LTC insurance contributions (collected along with health insurance), tax revenues, and co-payments • An appointed committee determines eligibility and level of need through reviewing ADL questionnaire and assessment results	• Program is administered by a national insurance entity and local governments have no role in the process • Only three levels of LTC need are recognized (Japan has seven levels) • There is provision for a cash benefit as well as services in-kind (however, cash benefit is only available in exceptional cases)

3.1.7 Future Challenges

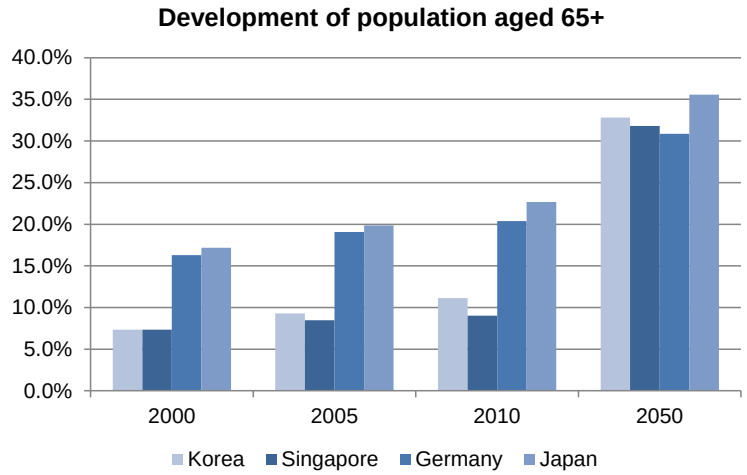
It is expected that population aging, societal changes and changes in family structure will increase the financial burden triggered by elderly care. The public LTC spending is projected to increase from 0.2% and 0.3% of GDP in 2000 and 2005 respectively to 2.3% - 5.1% of GDP in 2050, which is more than 20% larger than the average for countries in the OECD[18].

The Korean public LTC scheme will hence have to manage a significant increase in LTC spending as well as sustainability issues due to financing risks that challenge other public LTC insurance systems around the world.

3.2 Singapore

Singapore has a current population of 5.1 million of which 3.8 million are Singapore Citizens and Permanent Residents and 1.3 million are Non-Residents. Its proportion of the elderly population is still low today, however, Singapore is expected to mirror the development in Korea in the future:

Chart 9: Development of the elderly population aged 65 and over from 2000 to 2050[2]

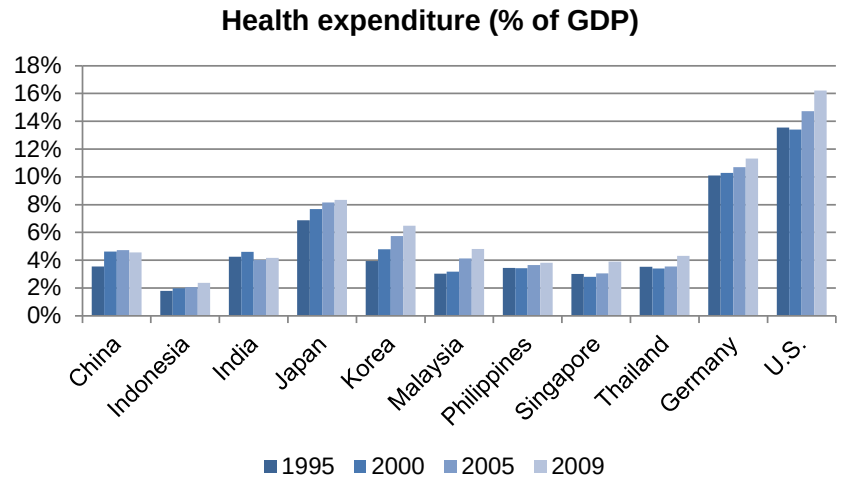


In addition, Singapore is projected to experience significant population aging, societal changes and changes in family structure as outlined in Section 2.

The philosophy of the Singapore government towards healthcare is to make good, affordable basic healthcare available to Singaporeans with a minimum of public subsidy, whilst promoting individual responsibility towards healthy living and medical expenses[19]. The element of co-payments from patients is a central feature of Singapore's approach to cost management.

Health care in Singapore is financed through a combination of a compulsory medical savings account (Medisave), a low-cost catastrophic illness insurance, and a state-funded endowment fund. With this approach, Singapore achieved a ranking of 6th position in the overall health system performance of the WHO[20] whilst keeping the spending among the lowest world-wide:

Chart 10: Health Expenditure (% of GDP)[6]



The government has embarked on a so-called 3-E approach (Elderfund, Eldershield, Eldersave) to help its citizens finance their future LTC expenses:

- Elderfund was set up in the year 2000 and serves as a means-tested safety net for elderly from households with lower income that pays for LTC expenses provided by selected voluntary welfare organisations. It is an endowment fund with a target capital of S$ 3 billion (about US$ 2.4 billion). Only interest generated from the fund is used to finance respective subsidies.

- Eldershield is an obligatory insurance scheme, which was set up in 2002 to protect against the cost of LTC expenses and which is run by the Singapore Ministry of Health (MoH). The government provides the framework for the scheme but the private insurance industry assumes the role of risk taker and administrator. When the scheme started in 2002, a tender went out to all Singapore insurers, and two companies were finally chosen for the period 2002 – 2007. A third Singapore insurer was added for the period 2007 – 2012 after another tender, and a new tender is expected later in 2012. The scheme provides a fixed monthly cash benefit to help pay for out-of-pocket care expenses.

- Eldersave was set up in 2010 to encourage the younger generation to set aside funds for future LTC needs.

In addition, the Singapore government directly subsidises some hospitals and service providers.

In the following, we will look at the Eldershield scheme in more detail.

3.2.1 LTC Providers

About 80% of primary healthcare is provided through some 2,000 private medical clinics. The remaining 20% is provided through 18 polyclinics in the public sector.

There are residential and community-based healthcare services that cater to the LTC needs of Singaporeans. These services include community hospitals, chronic sick hospitals, nursing homes, sheltered homes for the mentally ill, inpatient hospice institutions, home medical, home nursing and home hospice care services, day rehabilitation centres, dementia day care centres, psychiatric day care centres and psychiatric rehabilitation homes[21].

For example, there were 63 nursing homes offering 9,300 nursing home beds in Singapore in 2010. There have been reports about a significant increase in the waiting time for beds in nursing homes, in particular for beds in homes which are run by voluntary welfare organisations that offer subsidised beds. The MoH stated that it wants to increase the number of nursing home beds to 14,000 (+50%) by the year 2020[22]. On the other hand, the share of the population aged 65 and over is expected to increase from 9% in 2010 to 15.3% (+70%) in 2020, i.e., the demand for nursing facilities in Singapore is likely to continue to exceed its supply.

The providers are paid by patients on a fee-for-service basis. The patients can use the cash payments received under the ElderShield scheme to pay for the respective expenses, but will still have to pay any excess cost out of their own pocket if they do not qualify for

subsidies. The eligibility for subsidies is means-tested. Subsidies are paid directly to service providers to offset a part of the care cost[23].

3.2.2 Insuring Entity

ElderShield was designed and is monitored by the Singapore government, but it is currently offered and administered by three private life insurance companies at this stage. All three insurers offer the same premiums and benefits under the ElderShield scheme. Premium increases are only possible subject to approval by the MoH. Benefits are initially approved by the insurance companies; however, claimants can appeal to the ElderShield Arbitration Panel which is set up by the MoH and whose decisions are final and binding.

3.2.3 Eligibility

Eldershield is an obligatory insurance program, i.e. all Singapore Citizens and Permanent Residents who have a MediSave account are automatically invited into the scheme when they become 40 years old. It is possible to opt out of the scheme if a corresponding opt-out form is submitted to the respective insurer. Re-entry into the scheme is only possible subject to a health declaration and good state of health.

3.2.4 Financing

Premiums depend on age at entry and gender, and are payable annually until the age of 65. The premiums are not guaranteed, but increases have to be approved by the MoH after receiving an actuarial report from a consulting actuary appointed by the MoH and are capped at 20% over a five-year period. The payment of the premiums can be made from the medical savings account.

3.2.5 Beneficiaries

Policyholders are covered for whole life. Benefits are payable after a deferment period of 90 days if a policyholder is not able to perform at least three out of the following six ADLs:

- Washing
- Dressing
- Feeding
- Toileting
- Mobility
- Transferring

Benefits in the case of dementia are not explicitly covered, but are given if the above mentioned ADL requirements are met.

3.2.6 Benefits

When the ElderShield scheme was introduced in 2002, the scheme provided a fixed monthly cash benefit of S$ 300 (about US$ 240). Coverage is provided for the whole life, but benefits are only paid for up to 60 months per lifetime. In 2007, the benefit amount was increased to S$ 400 (about US$ 320) per month and the maximum benefit duration was increased to 72 months per lifetime for new entrants. Existing policyholders were given the option to upgrade their policies to the new benefit conditions.

Nursing home charges, on the other hand, can range from about S$ 1,000 to S$ 3,500 per month depending on the functional status of the person and the quality of accommodation (e.g., number of beds in one room)[22]. The provided benefits are hence rather basic.

The Singapore government therefore decided to supplement the basic Eldershield coverage available which can be purchased from the appointed private insurers by policyholders with a basic ElderShield policy. The supplemental policies provide benefits along the following lines:

- A monthly cash benefit which can increase the obligatory cover up to S$ 3,500 per month and which can extend the benefit period to the whole life;
- A lump sum benefit;
- A rehabilitation benefit;
- A dependent care benefit if the policyholder has at least one Child;
- A death Benefit.

Policyholders may opt to pay the premium for the supplemental policies from their medical savings account up to a limit of S$ 600 (about US$ 480) per year. Depending on the basic Eldershield coverage and gender, this amount allows to increase the obligatory cover at one of the appointed insurers to about S$ 800 – S$ 1,000 at entry age 40 and about S$ 500 – S$ 600 at entry age 60 without cap on the benefit duration.

3.2.7 Future Challenges

It has been reported that the opt-out rate of the ElderShield scheme has decreased from 38% in the year 2002 when the scheme was introduced to 14% in the year 2006[24]. There were approximately 810,000 in-force basic ElderShield policies in the year 2010, which implies that about 50% of Singapore Citizens and Permanent Residents aged 40 and above are covered by the scheme. Reasons quoted for the dissatisfaction with the basic Eldershield scheme are low monthly benefits, strict criteria for claims and short benefit durations[25].

Managing the future care expenses of those who opted out of the ElderShield scheme at a young age can be a political and economic challenge. The Singapore government might also be faced with pressure to allow re-entry at age 65 and above in the future.

There are about 190,000 supplemental policies in force in the year 2010, i.e., only about 14% of Singapore Citizens and Permanent Residents in the 40 – 65 age range have purchased additional LTC protection which enhances their basic coverage.

The ElderShield scheme is not a social insurance scheme, and higher income earners pay the same premiums as lower income earners. The burden of purchasing the LTC protection is hence significantly more severe for lower income earners. This might induce anti-selection of healthy people who hope for government subsidies should the need for care arise in their future life-time and who prefer to opt out of the scheme. The Singapore government may hence experience significant cost under the welfare programs in future.

3.3 United States

The origin of LTC coverage in the United States can be traced back to the passage of the Social Security Act of 1935 and other related welfare programs. It was during the great depression of the 1930s, a time that many Americans were unable to care for themselves, that the federal government had increased its role and involvement in the care of the aged, blind, and families with dependent children. Over the next several decades, the federal government expanded its role in financing care of the needy through the passage of the Medicare and Medicaid amendments to the Social Security Act in the 1960s. The advent of the Medicare and Medicaid programs not only provided social LTC protection to those who qualify for care but also fuelled the growth of the LTC industry in the U.S.

The healthcare oriented Medicare and the welfare-based Medicaid programs are the two major funding sources for LTC in the U.S. today. The circumstances under which Americans receive LTC assistance under each of these public programs are very different. Generally, the beneficiaries are either Medicare enrolees who are recovering from an acute illness or individuals who are eligible for Medicaid and qualify for LTC benefits based on well-defined means-test criteria. Due to a large unanticipated demand for care, each of these programs is suffering from insufficient funding. To ease financial burden on these public programs, alternatives (such as the Community Living Assistance Services and Supports Act that will be discussed later) have been considered to increase public-private partnerships and to enhance private LTC insurance in the U.S. However, there had been little success with these efforts -- participation in private LTC insurance remains very low.

Aside from the lack of success with the promotion of public-private partnerships, the private LTC market faces financial challenges and has a gloomy outlook -- many large LTC underwriters such as MetLife, Unum, Prudential and others have decided to stop issuing new policies for either all or a subset of their LTC business. The economy and low interest-rate environment make it especially challenging for insurers to keep their LTC business afloat. According to LIMRA (an industry research and consulting group), private LTC policy sales fell by as much as 24% in 2009. LIMRA also reports that there are about 7 million LTC policies in force (less than 5% total market penetration).

In the following, we will discuss the various LTC schemes in the U.S. in more detail.

3.3.1 Insuring Entity

LTC insuring entities in the U.S. are a combination of private insurance plans and government programs (Medicare and Medicaid). Medicare operates at the federal level only, while Medicaid has both federal and state components.

3.3.2 Eligibility

Eligibility for LTC in the U.S. is restricted unless one carries a private LTC policy. Eligibility requirements for Medicaid are based on income and personal assets (i.e., means-tested) and vary by state. Medicare was created to provide healthcare coverage to individuals who are age 65 and older.

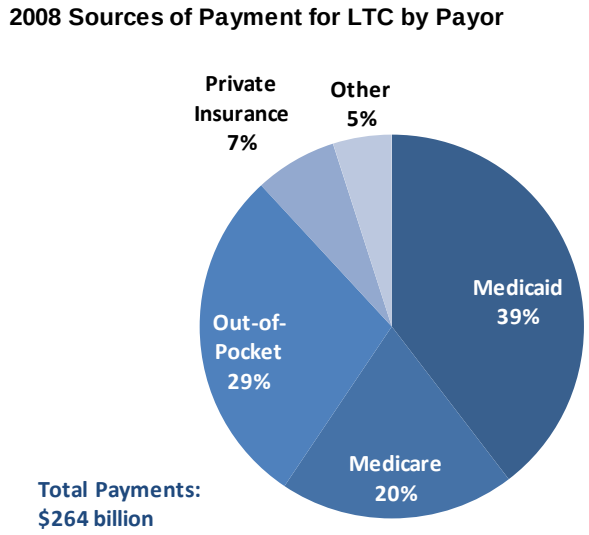
Providing less restricted and broad LTC coverage has been one of the primary LTC reform considerations in the U.S. LTC program alternatives have been designed to overcome some of the existing restrictions, e.g., means-test. The Community Living Assistance Services and

Supports (CLASS) program is a recent example of the alternatives that was determined actuarially unworkable and halted in its implementation.

3.3.3 Financing

In the U.S., a majority of the funding for LTC is provided by Medicare and Medicaid. Close to 40% of LTC is funded by Medicaid and 20% by Medicare while less than 10% is financed by private LTC insurance. Much of the remainder (29%) constitutes out-of-pocket costs paid by those receiving care or by their families. The proportion of out-of-pockets costs for LTC in the U.S. is larger than in most other countries around the world. The chart below illustrates the LTC funding distribution in the U.S.

Chart 11: Sources of LTC Payment[26]

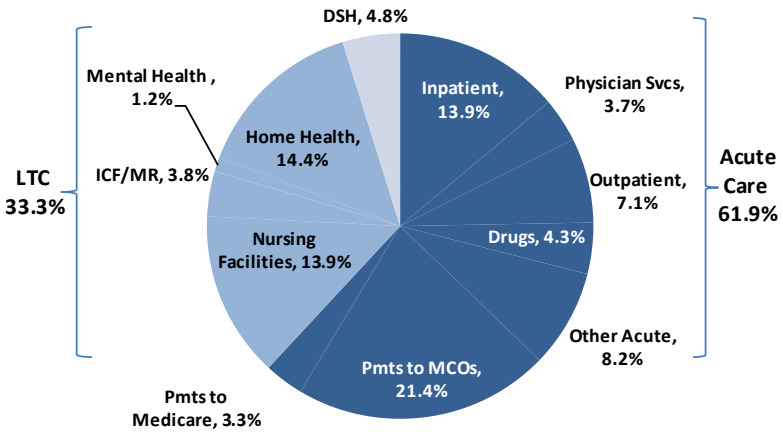


While not included above, it is important to note that well over half of all LTC is informal, unpaid assistance provided by spouses or other relatives. American Association of Retired Persons calculates that in 2009 the economic value of this care was $450 billion (which is almost double of all the formal LTC costs).

The primary payer of LTC in the U.S. is Medicaid. Each state manages its own Medicaid program, while the program is funded on a pay-as-you-go basis through a combination of general tax revenue from the state and federal governments. Medicare, the other public program, is solely administered and funded by the federal government. Medicare is funded by a combination of pre-funding and pay-as-you-go mechanisms, e.g., payroll tax and beneficiary premiums. Both Medicare and Medicaid provide insurance coverage for various healthcare needs that include LTC.

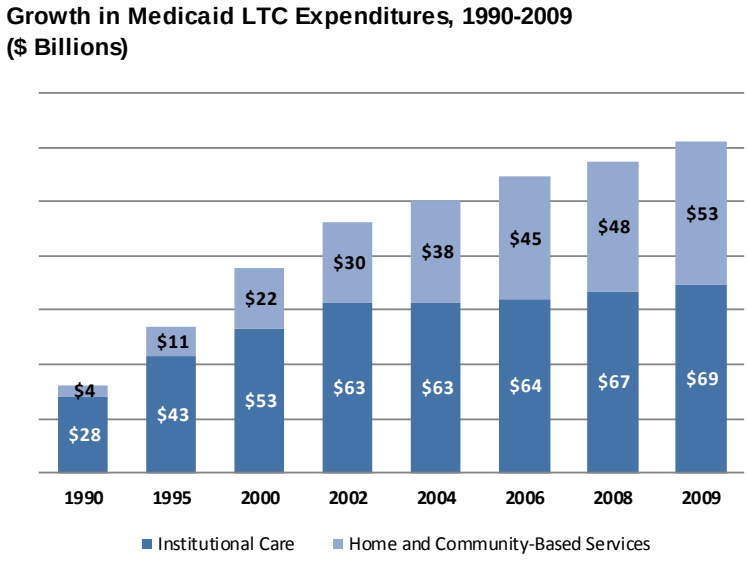
A future funding crisis awaits the Medicare and Medicaid programs. The shrinking Medicare revenue as the number of workers per Medicare beneficiary declines is a critical problem. On the other hand, the rapidly increasing Medicaid LTC expenditures, the second largest cost component of the program, present a different financing challenge.

Chart 12: Distribution of Medicaid Spending[27]



From 1990 to 2009, the Medicaid LTC expenditures have increased by close to 280%. The rapid growth associated with home and community-based services is the primary contributor to that increase.

Chart 13: Growth in Medicaid LTC Expenditures[27]



3.3.4 Beneficiaries

The Medicare program provides limited LTC coverage as an entitlement without means-testing. Generally, individuals age 65 and older who are U.S. citizens or permanent residents that worked at least 10 years would qualify for Medicare. There are a few exceptions that qualify other ill and disabled individuals who are not yet age 65 for Medicare (e.g., permanent kidney failure).

Medicaid is a means-tested safety net program, and its eligibility varies by state. In order to receive Medicaid LTC coverage, a candidate must meet certain financial criteria and undergo a state assessment to determine the need for care. The financial criteria and minimum level of care needed to qualify for Medicaid are defined by each state. The

minimum level is typically tied to a person's ability to perform a certain number of ADLs without assistance.

3.3.5 Benefits

There is a wide variation of benefits of LTC programs in the U.S. Beneficiaries' out-of-pockets costs vary by program.

Medicare provides limited LTC coverage. It covers up to 100 days of care in a skilled nursing facility (SNF) after an acute care episode for each benefit period. Medicare pays 100% of the first 20 days of a covered SNF stay. A beneficiary co-payment of $144.50 per day is required for days 21-100 in 2012. Medicare also covers up to 100 home health visits per period of illness following a hospital stay; additional home health benefits could be available. In addition to post-acute care, Medicare covers hospice care at the end of life.

Unlike Medicare, Medicaid covers a broad continuum of LTC ranging from institutional to home health care that address a beneficiary's limitations in performing basic ADLs such as bathing, toileting, dressing, cooking, and eating. The type and level of coverage varies from state to state. However, all states must provide SNF as part of the state Medicaid benefits.

Most private LTC insurance policies cover both institutional and home health care for policyholders who meet an ADL or cognitive impairment requirement. However, the benefits period is may be only for a limited time, and at an agreed amount per day which may be inflation-protected, and only after a waiting period; few older policies provide coverage for life. Further, premiums are usually paid for life or until LTC payments begin, and are not stopped at age 65.

3.3.6 Future Challenges

The U.S. spent 1% of its GDP on LTC in 2007, and this share is expected to at least double by 2050[23]. With a significant portion of LTC financed by Medicaid and less than 10% paid by private insurance, the existing system for financing LTC may be unsustainable. The U.S. is in a dire need for a viable LTC reform that provides broad coverage, controls growing costs of care, and addresses future increases in LTC demand driven by the retirement of the baby boom generation.

To address these challenges, there have been various efforts in the past decade to reform LTC financing in the U.S. and they have mostly focused on enhancing private insurance. Some of these reforms include tax incentives, public/private partnerships, and marketing campaigns to encourage individuals to purchase private LTC insurance. However, these initiatives were largely unsuccessful in changing the LTC coverage landscape in the U.S.

Thus a more far-reaching solution may be needed. A recent example of that effort would be the CLASS Act that was passed as part of 2010 Health Reform. The CLASS Act would have created a voluntary government LTC insurance program, designed to assist in maintaining independence by providing cash benefits for those with functional disabilities to purchase non-medical services. Enrolment in the program would have been automatic for employees of participating employers, but with the ability to opt out. In October 2011, however, the U.S. Secretary of Health and Human Services declared the CLASS program to be actuarially unworkable and work on the program's implementation ceased. More national LTC reform discussion is underway.

3.4 Supposition

The need for providing basic LTC coverage has arisen only in recent years. It is apparent that there is no single best solution for states to provide LTC coverage for their citizens. Every country irrespective of its current scheme is most likely challenged with financing future care cost.

There is also a limitation to the transfer of lessons learned in a specific country to another country. For example, a new component of the social security system which provides basic LTC coverage will have to be intertwined with the existing health insurance coverage provided by the social security system. The roots of the German public health system, for example, date back to 1883 when the system was initiated by Imperial Chancellor Otto von Bismarck. The peculiarities of this system had to be considered when the new public LTC scheme was launched in Germany in 1994, e.g., how to treat citizens who could opt out of the public scheme and who had purchased health coverage from private health insurers.

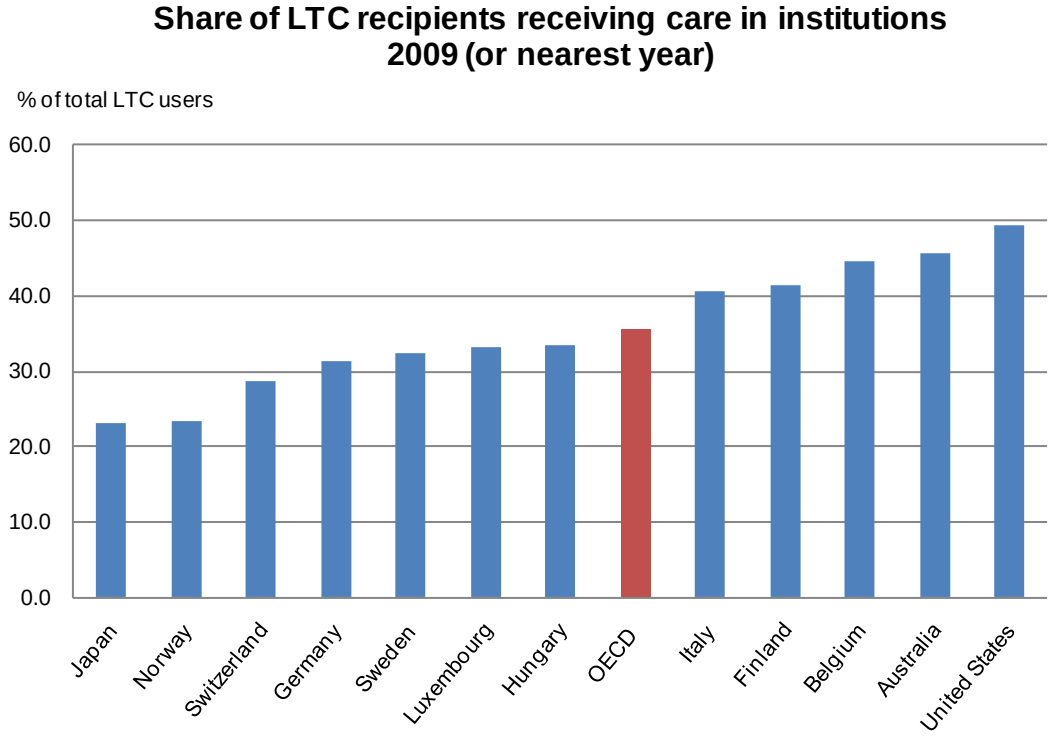
4 Private LTC Insurance

4.1 The role of care provided by the family

It was traditionally seen as one of the core responsibilities of families to manage any kind of sickness at home. Elderly people who needed care and who could not rely on such family support had to enter alms houses. Families tried to avoid the social stigma attached to having a relative stay at an alms house and the large majority of elderly was cared at home.

It is a development of the last century mainly in western countries that a significant portion of care has been shifted to institutions. The following chart shows the share of institutionalised LTC recipients among people who receive LTC by paid providers:

Chart 14: Share of LTC recipients receiving care at institutions, 2009 (or nearest year)[9]



Considering the unpaid care provided by family members, it can be concluded that much less than 50% of care is provided at institutions.

In Asia, the proportion of care provided by professional LTC providers is even less. The low percentage shown in the above chart for Japan is indicative for most Asian countries. One reason for the low proportion is a lack of supply of LTC service providers as outlined in Section 3.1.1 and 3.2.1. It was traditionally also the duty of the spouse of the oldest son to provide care for the parents. There used to be a stigma attached to shifting this responsibility to strangers. Instead, elderly were often cared in hospitals as a substitute. It has, for example, been reported that 21% of bedridden elderly were hospitalised in Japan in 1994[28]. However, countries have in the meantime started to take measured against the shift of care cost to the public health system. Instead a trend has emerged in a number of Asian countries, notably in Singapore, Taiwan, Hong Kong, and South Korea, to employ live-in foreign domestic workers, e.g., from the Philippines, to provide care for the elderly[28]. LTC in

Asia is overall predominantly provided by families or foreign domestic workers, and to a much lesser extent by third party providers.

It will be challenging to families in Asia to continue with the tradition of providing care within the framework of the family in the future as outlined in Section 2. Most families, in particular, cannot afford to forgo the income of the traditional caregiver, e.g., due to increasing cost of living and school education for the children. This is in particular true for families living in large metropolitan cities.

Thus there is demand for private LTC products which provide financial support to family members who need to stay at home to care for the elderly or which allow employing a foreign domestic worker to care for the elderly. The large majority of LTC products found in Asia hence pay a cash benefit if the need for care arises.

4.2 The role of private LTC Insurance

Private LTC protection has been available for a considerable period of time. In Japan, for example, LTC policies have been on sale since the 1980s. The product concept has been introduced to many other markets in Asia, including Hong Kong, South Korea, Singapore and Taiwan.

Customers, who are interested in purchasing LTC protection, can be segmented as follows:

- Young adults,
- Elderly people who do not need care (yet),
- Elderly people who need care.

The risk of needing care at young age is very low. The main purpose of buying LTC coverage at a young age is to pre-fund LTC services needed at old-age or to secure insurability against LTC risks at old-age. However, young adults tend to have many financial needs and commitments, e.g., travels, purchase of a car, flat or house, school education of their children. Purchasing insurance for immediate risks such as sickness, accident, disability, death, unemployment or saving for retirement is usually given more importance than purchasing insurance for LTC. Sales of LTC products to young adults have hence been sluggish.

The main purpose of elderly people, who do not need care yet and who purchase LTC, is to protect assets and the inheritance of their children against the high cost of LTC and to reduce the need for the family to provide care. Selling LTC to elderly people has proven to have its own challenges, for example:

- The products are seen by the public to be expensive, and especially to retirees on fixed income
- The sales force is usually not trained to sell insurance products to the elderly
- Complex and extensive underwriting is required when elderly purchase LTC

- The products usually do not provide surrender values, i.e., elderly people purchasing such a product will experience a loss of control of available assets

- The premium rates are usually not guaranteed which means that people enter into a financial commitment without knowing the value or future cost of the product.

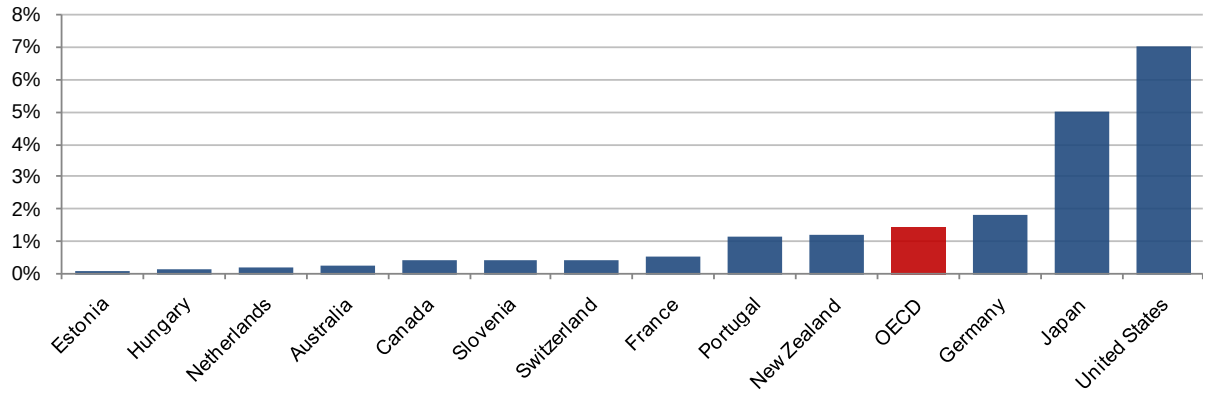
Insurance companies have tried to address these challenges, e.g., setting up separate distribution channels focussing on elderly people or locking in premium rates from a certain attained age. However, these measures have shown limited success in the best case, and did cost companies dearly in the worst case. For example, premium and benefit guarantees of initially 10 years were offered by insurance companies in the United Kingdom for LTC products sold in the 1990s. Eventually, the guarantees were extended to attained ages beyond age 70. The loss ratios exceeded 100% eventually and caused large losses to the insurance companies[29].

Elderly people, who are already in need of care, may want to purchase a LTC policy to remove the uncertainty whether accumulated assets are sufficient to cover future care cost. The relevant policies are usually referred to as Immediate Care Annuities. Such policies are unlikely to significantly increase the prevalence of LTC protection in a country as only wealthy persons will have the financial means to pay the premiums required to purchase such protection.

The focus of insurance companies in a country on these target groups very much depends on the characteristics of the relevant public LTC system. In Germany, private LTC protection is mainly sold to people who opt out of the public LTC scheme or as a top-up of the public LTC scheme. The typical average age at entry for private LTC plans is between the age of 30 and 40[30]. In the United States, private LTC protection is mainly sold to people who are not eligible for Medicaid, which is targeted to the poor. The average age at entry for private LTC plans is around 59 for individual insureds and 46 for group insurance policies[31].

Whatever the marketing approach, private LTC has not seen many success stories. Only a small percentage of the population is typically covered by private LTC product and private insurers account for only a small share of the overall LTC spending.

Chart 15: Share of private LTC policies among total LTC spending9



4.3 The development of private LTC Insurance in Korea

Private LTC policies have been introduced in Asian in a number of countries. In the following, we will look at the development in Korea in more detail.

The first LTC products in the Korean market

Insurance companies in Korea have recognised the need for private LTC protection at an early stage. The largest three life insurance companies in Korea, for example, have been selling private LTC protection, which cover the risk of failing ADL and dementia, since 2003. The respective products have been designed along the following lines:

Risk	Benefits Trigger	Benefits
Death without LTC	Payable if the insured dies before LTC is diagnosed.	A lump benefit equal to the mathematical reserve.
LTC Diagnosis	Payable on diagnosis of care needs, i.e., failure of ADL or dementia as explained in the text in more detail.	A lump sum benefit of 5 times the monthly LTC annuity benefit.
Care Needs	Payable for as long as the insured needs care, subject to a minimum of 24 monthly payments and a maximum of 120 monthly payments.	A fixed monthly LTC annuity benefit.
Death after LTC Diagnosis	Payable if the insured dies after LTC is diagnosed.	A death benefit is payable if the claimant dies before 24 monthly payments have been made. The death benefit is equal to the remaining balance of the monthly payments.

The products pay only fixed cash benefits under these types of product design. The benefits do not relate to the actual incurred cost of care.

A person is understood to require care needs if he is unable to move (walk) without the help of another person and is in addition unable to perform at least one of the following four ADL without help of another person:

1. Eating
2. Using the toilet
3. Bathing
4. Dressing

A person is also understood to require care if he suffers from organic dementia and has a rating of 3 or higher on the Clinical Dementia Rating scale.

The benefit trigger was hence rather strict.

A number of product features increase the cost of the already expensive LTC coverage:

- The LTC annuity payable under these products does not consider the possibility of recovery
- It has not been uncommon to add survival benefits to the coverage provided the policyholder survived a specified period after policy commencement without requiring LTC or a specified period after LTC diagnosis
- Korean insurance regulation requires companies to pay surrender values under the products.

The private LTC products were the first products in the Korean market with non-guaranteed rates, i.e., the premiums could be adjusted by companies during the policy duration subject to approval of the regulator. This new feature had to be explained to applicants during the sales process and was an additional challenge.

The sales volume of these LTC products had been disappointing. It is estimated that overall only a couple of 10,000 policies of this product had been sold[32].

Consequently, a number of efforts were undertaken to vitalize the sales of LTC products in the Korean market. For example, the following product concepts have been explored by private insurers.

Accelerated-type LTC products

Accelerated-type LTC product is a whole life insurance product that prepays the underlying death benefit in case the need for LTC is diagnosed or an annual annuity in case of LTC care need. The respective product has been designed along the following lines:

Risk	Benefits trigger	Benefits
Death without LTC	Payable if the insured dies before LTC is diagnosed.	Sum insured.
LTC Diagnosis	Payable on diagnosis of care needs.	20% of the sum insured on diagnosis.
Care Needs	Payable for as long as the insured needs care, but not exceeding 80% of the death benefit.	8% of the sum insured per annum.
Death after LTC Diagnosis	Payable on death of the insured.	100% of the sum insured - LTC Diagnosis benefit and Annuity benefits paid due to care needs.

A person who is diagnosed as needing care and dies two years after the diagnosis would hence receive 20% of the sum insured on diagnosis and 8% of the sum insured for each surviving year. 64% of the sum insured would be paid to beneficiaries on his death.

This product type has seen nice growth in the United States where it is known as Combination Life product[33]. The additional cost of this acceleration feature would be in the order of 10% of an underlying Whole Life policy for males, and 25% of an underlying Whole Life policy for females[34].

The success of this product in Korea has, in contrast to the United States, been very limited. It is estimated that not more than 0.3% of the total in-force premium accounts for such LTC products in the year 2009. The lack of success is most probably related to the similarity of the product to Critical Illness acceleration plans, which advance a portion of the death benefit in case the policyholder is diagnosed with one of the covered critical illnesses (e.g., cancer, heart attack, and stroke). Critical Illness acceleration plans are popular and widely purchased by consumers in Korea, and thus there is not much demand to the similarly structured Accelerated-LTC policies.

Coordination of the Private LTC Products with the Public LTC Scheme

The definition of private LTC policies has traditionally been based on ADL and Dementia, whereas the public scheme applies a more complex assessment for care needs which, however, allows for wider coverage than private LTC policies. A mismatch between the private and public LTC coverage is hence not an exception.

Some companies reacted by requiring that both the definitions of the private and the definitions of the public scheme should be met for a LTC claim to be valid. Whilst this approach avoided the problems of a mismatch and protected private companies from weaker claim assessment standards than in the public scheme, it provided only very narrow coverage.

Policies which provide coverage if the benefit trigger of the public scheme is met have been introduced in the meantime. However, it seems that the wider coverage has not resulted in an uptake of sales.

Including LTC Coverage in the Scope of Critical Illness Coverage

A more successful approach of offering LTC coverage to policyholders has been the inclusion of LTC within the scope of Critical Illness acceleration policies that advance a portion of the death benefit in case the policyholder is diagnosed from one of the covered critical illnesses. The additional cost of adding LTC to the scope of such Critical Illness policies could be in the order of 5% - 10% of a Critical Illness product which does not provide such LTC coverage.

Other LTC Products

There are also other products in the Korean market that allow funding LTC expenses; for example:

- Acceleration features that resemble the design of Terminal Illness riders. The policyholder could receive LTC benefits under such plans if he or she needs care. The benefits payable would be the discounted death benefit after reflecting mortality and interest.
- Annuity products that provide double of the annuity benefit in case the insured requires care. Such products are offered as base plans and annuity conversion riders which are attached to protection base plan.
- Reverse mortgages, offered by the Korea National Housing Corporation.

Current state

Korea has gone through a short period of exploring LTC product concepts which have been selling in other markets world-wide.

Nonetheless, all attempts to vitalise the LTC market in Korea have not resulted in a success. There is little integration and coordination between the private and the public LTC sectors in Korea, and the challenge of increasing the prevalence of private LTC protection is still unmet.

5 Increasing the prevalence of private LTC

The trends outlined in Section 2 will result in an unprecedented increase of the elderly population across the globe. As a result, families will not be able to maintain the current level of care provided within the framework of the family. It will require the support of professional care provided at home and by institutions to provide adequate care. The resulting care costs are projected to bring social security systems to the brink of failure, and states are most likely not in a position to absorb the cost in the framework of welfare systems.

An increased contribution from private LTC protection is hence much needed.

5.1 Increasing the prevalence of private LTC protection at advanced age

For people at advanced age, it is only healthy people with higher income and wealth who can purchase private LTC protection:

- It has, for example, been reported that more than 40% of Americans over age 70 needed help with at least one ADL or instrumental ADL in the 1990s[35]. The strict underwriting requirements of private LTC products at advanced age hence leave many elderly applicants without coverage.

- The risk of needing care significantly increases by age: Whilst the risk at age below 60 is 0.07% on average, the risk increases to 0.9% and 4.3% at age 60 – 79 and 80+ respectively in the United States[36]. Purchasing LTC protection at old-age is hence costly.

The hurdle of high cost remains even if states introduce obligatory schemes which address anti-selection risks and allow reducing underwriting requirements.

It has been suggested that adult children could step in and purchase private LTC protection for their parents. This approach makes sense in particular in countries in which children are ultimately responsible for the care of their parents. Respective legislation has, for example, been introduced in Germany and Singapore. But today's generation of adult children is already trapped between paying for education of their children, maintaining their life-style and funding their own future LTC expenses. There will not be many children who can afford to fund the care cost of their parents in addition.

It is hence unlikely that efforts to increase private LTC protection at advanced age will have a significant impact.

5.2 Increasing the prevalence of private LTC protection at younger age

Efforts to increase the prevalence of private LTC protection should hence be addressed at younger age. But increasing the prevalence of private LTC at younger ages has its own challenges: LTC insurance is an abstract good for which costs are immediate but benefits are much delayed if purchased at young age.

States all over the world have recognised the dilemma that young people are reluctant to take provisions for such delayed benefits many decades ago. For example, many countries have taken one or more of the following steps to ensure that young people save for retirement, which has similarly delayed characteristics as LTC coverage:

- Introduction of a public pension scheme which requires individuals to save for retirement
- Introduction of a framework for employer-sponsored pensions to provide employees with retirement income
- Introduction of incentives, typically in the form of tax advantages, for the wider public to take private provisions for old-age.

Germany, for example, has embarked on a 3-pillar approach under which compulsory contributions towards a state pension scheme have to be made, employees are encouraged to participate in the employer-sponsored pension schemes and incentives are provided for voluntary savings towards retirement.

LTC insurance has only more recently been recognised as a crucial product which needs to be approached in a similar fashion. Relevant guidance to young people for taking provisions for future LTC needs can be given by the state and insurance companies.

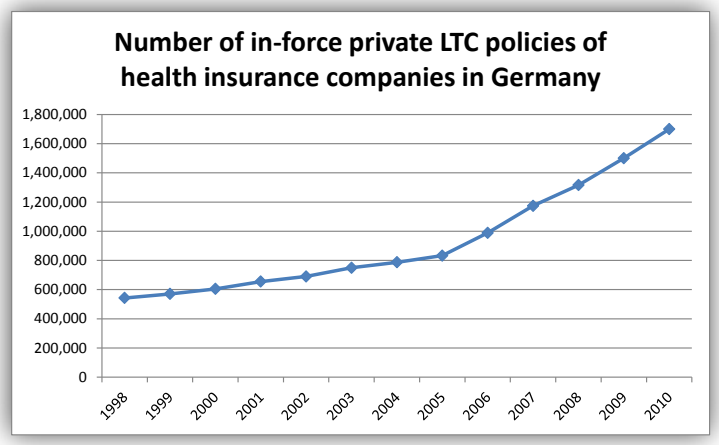
5.2.1 Guidance provided by the state to increase the prevalence of private LTC protection

Introduction of a public LTC scheme which provides basic protection

People are unlikely to purchase private LTC policies as long as there is uncertainty about the scope and coverage of a state-sponsored scheme. The main concern is that any insurance coverage which is purchased now might be duplicated by a state-sponsored solution at a later date. There is also a tendency towards a general belief that "the government will pay for most of the costs of LTC if services are ever needed."[32]

It is expected that increased awareness for the risks of LTC and certainty about the benefits provided by the state, which go along with the introduction of a public LTC scheme, will drive the demand for private LTC protection. The number of private LTC policies supplementing the obligatory cover in Germany, for example, has grown by more than 5 times since the introduction of the public scheme. Recently, growth rates in the order of 15% per annum could be observed.

Chart 16: Number of in-force private LTC policies of health insurance companies in Germany[37]



Today, about 3.6% of the German population over age 40 own such a policy.

Providing tax incentives for private LTC coverage

Tax incentives are reducing the purchase price of private LTC policies and are intended to increase demand. Studies have found that tax incentives can be an important factor in convincing people to consider buying a LTC policy:

- A study conducted by the Health Insurance Association of America[38] suggests that 81% of prospective buyers would be more inclined to purchase a LTC policy if the premium could be deducted from taxable income.

- Another study suggests that tax subsidies can increase the number of in-force policies by 28%[39].

There are conflicting reports whether the decrease in tax revenue can be offset by reduced expenditures in the public welfare system[40,41].

Tax incentives typically provide advantages mainly to high income and wealthy individuals as most tax schemes exhibit progressive tax rates. Direct subsidies towards the premium of a private LTC policy, which meets a standard minimum benefit design set by the state, may hence be more efficient in increasing the prevalence of private LTC policies than granting tax incentives.

Introduce a framework for covering LTC in employer-sponsored group insurance

The main aspect of offering LTC coverage in the framework of employer-sponsored group insurance is that the relevant premiums are tax deductible for employers and not taxed as income for the employees. The benefits payable under the relevant LTC plans might be paid tax-free.

The purpose for employers to offer LTC in the context of their group insurance plans is to gain a competitive advantage and retain current employees, attract new employees and to provide a tax-qualified alternative to increase salaries. The advantage for employees is to benefit from lower premium rates and less stringent underwriting requirements.

The state could also re-define the minimum standard of tax-qualified employer-sponsored pension plans: It could be required that all employer-sponsored pensions have to allow for the payment of a multiple of the standard annuity benefit if the retiree needs LTC. Even existing schemes could be covered by allowing retirees to forfeit a percentage of their regular pension benefits in exchange for a LTC benefit.

5.2.2 Guidance provided by insurance companies to increase the prevalence of private LTC protection

Also insurance companies can provide guidance to its applicants to increase the prevalence of private LTC protection.

Two life insurance companies in Japan, for example, sell LTC coverage as an integral part of their main products: Their products provide for a 10% acceleration of the death benefit in case the insured needs care. Policyholders will hence benefit from basic LTC coverage at low cost.

5.3 Conclusion

It will require the joint efforts of the state and private insurers to increase the prevalence of private LTC polices. Chances to increase the prevalence rates of private LTC policies are higher if relevant efforts are directed towards young people.

Measures which can be taken are along the following lines:

- Introduce a public LTC scheme which provides basic coverage.
- Provide direct subsidies towards purchasing private LTC policies which meet minimum standards.
- Introduce a framework for covering LTC in the context of company pensions.
- Include coverage for the risk of LTC into the scope of all basic products of an insurance company.

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