



Institute  
and Faculty  
of Actuaries

# The Long-term Sustainability of the NHS

IFoA response to Lords Select Committee

21 September 2016

## **About the Institute and Faculty of Actuaries**

The Institute and Faculty of Actuaries is the chartered professional body for actuaries in the United Kingdom. A rigorous examination system is supported by a programme of continuous professional development and a professional code of conduct supports high standards, reflecting the significant role of the Profession in society.

Actuaries' training is founded on mathematical and statistical techniques used in insurance, pension fund management and investment and then builds the management skills associated with the application of these techniques. The training includes the derivation and application of 'mortality tables' used to assess probabilities of death or survival. It also includes the financial mathematics of interest and risk associated with different investment vehicles – from simple deposits through to complex stock market derivatives.

Actuaries provide commercial, financial and prudential advice on the management of a business' assets and liabilities, especially where long term management and planning are critical to the success of any business venture. A majority of actuaries work for insurance companies or pension funds – either as their direct employees or in firms which undertake work on a consultancy basis – but they also advise individuals and offer comment on social and public interest issues. Members of the profession have a statutory role in the supervision of pension funds and life insurance companies as well as a statutory role to provide actuarial opinions for managing agents at Lloyd's.



Lord Patel  
Chair, Select Committee on the long-term  
sustainability of the NHS  
House of Lords  
Houses of Parliament  
London, SW1A 0PW

21 September 2016

Dear Lord Patel

## **IFoA response to the Select Committee's Call for Evidence on the long-term sustainability of the NHS**

### **Summary**

1. It is important that the Committee considers social care in its assessment of the sustainability of the NHS. Social care needs are rising, yet State spending is falling. The affects of this are already being seen with the proportion of delayed transfers of care attributable to a lack of social care provision increasing. In order to create a sustainable framework in England, both health and social care funding need to be considered.
2. The funding models for the NHS and social care are different. If the future of health and care funding is to be sustainable, there needs to be a balance between these two approaches, and therefore, between Government and individual funding. International experience and pensions policy here in the UK demonstrate that governments can take a lead role in increasing the number of people saving towards future costs. Success has been achieved through awareness raising campaigns and implementation of national social insurance and saving programmes.
3. Our recommendations to the Committee are:
  - a. Widespread public engagement is needed on the cost of social care
  - b. Saving for care must be incentivised not penalised
  - c. Telehealth and wearables can encourage healthier living and create efficiencies in the health care system

### **Response**

4. The Institute and Faculty of Actuaries (IFoA) is the UK membership body for actuaries. Health and care is a growing area for actuarial work as actuaries collaborate with other health professionals in financial planning for the NHS, researching ways to restructure funding models to meet the demands of an ageing population and to offer health and care insurance solutions.
5. To achieve long-term sustainability, and intergenerational fairness, it seems reasonable to find someway of ensuring that those benefitting from longer lives and access to health and care services contribute to this increasing cost. This is particularly important as the 'old age

dependency ratio' (the number of people over the State pension age for every 1,000 people of working age) is increasing. This is resulting in a growing proportion of State expenditure being focused on those over State pension age, including health, social care and other age-related benefits.<sup>1</sup> We wish to bring to the Committee's attention a recent report by the Government Actuary's Department (GAD) 'A Cohort Approach to Social Care Funding'.<sup>2</sup> In this paper, GAD suggests tailoring the approach to social care funding by generation to develop solutions for the longer term. A further policy option that is being explored elsewhere in Government, and where the actuarial profession has completed further analysis, is increasing State pension age, to increase the number of people making National Insurance contributions.<sup>3</sup>

6. The IFoA welcomes the Committee's commitment to long-term sustainability. Moving towards a health and care system that is clear on what social care the State can afford to provide could be politically risky in the short-term, but it will enable people to plan and prepare for any additional needs not met within the free at the point of need funding arrangement. In particular, we note that Government could do significantly more to raise awareness amongst the public that they will need to fund their social care, unless their needs are substantial or they fall below the means-testing thresholds. Without this, people will continue to have to make decisions about their care at the point of need, which could result in additional stress at what will already be a difficult time.
7. We ask the Committee not to overlook the importance of social care funding in its assessment of the long-term sustainability of the NHS for the following reasons:
  - a. The number of people with social care needs in later life is rising. The Department of Health estimates that by 2018 there will be over 1 million more people with three or more long-term conditions in England than there were in 2008.<sup>4</sup> Despite this forecast of an increase in demand, between 2009 and 2014, local authority spending on social care for older people fell in real terms by 17% and the number of people receiving publicly funded social care fell by 25% from 1.7 million people to 1.3 million meaning only those with substantial or critical needs are receiving public funding.<sup>5</sup>
  - b. An under-funded social care system and an increase in demand is already having a detrimental impact on the NHS, with the proportion of delayed transfers of care attributable to social care increasing between 2014 and 2015 from 26.7% to 31.1%.<sup>6</sup> The National Audit Office has estimated the cost of treating older patients in hospital, who no longer need to be there, in the region of £820 million per annum. It notes this is a conservative estimate.<sup>7</sup>
  - c. The 2015 Spending Review reaffirms the Government's commitment to integrating health and care. In addition to considering what this means for delivery, there is also a disparity between the funding of these two systems. Funding of the NHS is through general taxation, yet funding for social care is largely through the individual's savings and housing wealth, unless they are eligible for means-tested benefits. Both the

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<sup>1</sup> Cracknell, R. (2010) *The ageing population*. Key issues for the New Parliament 2010 House of Commons Library Research

<sup>2</sup> Government Actuary's Department (2016) *A Cohort Approach to Social Care Funding (September 2016)*

<sup>3</sup> IFoA (2016) *IFoA submission to the State pension age review* [Available online: <https://www.actuaries.org.uk/documents/state-pension-age-review-foa-submission-sir-john-cridlands-review>]

<sup>4</sup> Department of Health (2012) *Long Term Conditions Compendium of Information: Third Edition*

<sup>5</sup> The Kings Fund (2015) *How serious are the pressures in social care* [Available online: <http://www.kingsfund.org.uk/projects/verdict/how-serious-are-pressures-social-care>]

<sup>6</sup> ADASS (2016) *Submission to the Health Committee's inquiry 'Spending Review impact on health and social care'*

<sup>7</sup> National Audit Office (2016) *Discharging older patients from hospital HC 18 Session 2016-17*

health and social care systems already face a deficit based on what the Government has committed to spending over the rest of this Parliamentary term. The integration of the two systems creates an opportunity for debate about the balance between State provision and self-funding across the health and care system.

8. For these reasons, we have focused our response on how the Government might strike a balance between Government and individual funding to meet health and care needs within a sustainable framework. Financial services can play a role in helping self-funders to meet their care costs and the IFoA has completed a series of research papers, which we have detailed in this response, on how this market might develop in a way that is complementary to Government funding. We would welcome the opportunity to share this with the Committee and discuss it in further detail.

### **Resourcing issues**

*Q. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care?*

*Q. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?*

9. Our analysis of international funding systems could be of use to the Committee in addressing both of the questions highlighted above.
  - a. In France, local governments fund around 70 percent of the care budget, with the remaining 30 percent being funded by central government. Central government funding is through employers' social security contributions, as well as general taxation, with additional funding coming from France's Solidarity Day. On Solidarity Day, employees donate their earnings from that day to fund care. This Government-led public awareness campaign has also led to a growth in private insurance. Less than 1% of care spending in 2007 was from private insurance provision, but by 2010, 15% of the population, aged over 40, had a care policy. This growth has been mostly attributed to the public becoming more aware of the risks and costs involved, as well as the gaps in public provision.
  - b. In Germany, there is a mixture of social and private insurance schemes. Compulsory social insurance was introduced in 1995. However, those with higher incomes, civil servants and the self-employed may opt for private insurance instead of the social insurance. Contributions to social insurance are split between the individual and the employer. This structure enables both public and private systems to sit alongside one another.
  - c. In 2000, Japan created a care social insurance programme. This programme covers domiciliary and residential care and the benefits are set nationally. It is compulsory for those over 40 years of age to contribute and it offers access to social care for those aged over 65. The level of contribution is dependent on income, but the benefit is dependent on need, as opposed to being means-tested.
  - d. The Netherlands set up a publicly funded scheme to ensure no one had high expenses for meeting care needs. However, this has undergone review as costs have risen by 66 percent from €14bn to €23bn between 2000 and 2010. This has meant the system has been in constant flux.
  - e. Medicaid in the US is funded through general taxation and is a means-tested welfare programme for the poorest. The private insurance market is relatively well developed with products covering both domiciliary and residential care. The 2010 Affordable

Care Act regulates and subsidises health insurance to make it more affordable and as of 2016, large employers have to provide health-coverage to full-time workers.<sup>8</sup>

10. Our conclusions from this research are that whilst Japan and the Netherlands have taken an approach that has a greater emphasis on publicly funded provision for care, an approach that aligns with the NHS funding model, the costs associated with this, particularly in the Netherlands, have led to a costly and potentially unsustainable system. Therefore treating social care the same as health care, and being funded through taxation could result in greater proportion of the Government's budget being spent on health and care than is already the case. The Government should consider whether this would be sustainable in the long-term when integrating health and care.
11. On the other hand, the US has taken steps to increase private provision by creating a health insurance market that is affordable for consumers. By contrast, the market for long-term care financial products has been slow to develop in England where these products are seen as unaffordable for the majority of people. Germany has achieved a system where public and private funding sit side-by-side and where employers also contribute. The German system mirrors the UK's approach to auto-enrolment, where there has been success in driving up the number of people saving for their retirement. Perhaps a similar approach could be adopted for care. Both of these examples highlight that there is a key role for the Government in increasing levels of saving for care and in stimulating a market that is affordable.
12. Finally, France managed to significantly increase the amount of private provision for care through a Government-led public awareness campaign. In the Care Act 2014, for the first time the UK Government legislated for changes to the current system with the aim of encouraging innovation in this market. The lack of market response was cited as one of the reasons for the deferral of these reforms to 2020. If the Government genuinely wants people to be aware that they may have to fund care needs themselves and to make provisions then we believe the following needs to happen:
  - a. Widespread public engagement is needed to create the scale of demand required for any financial product solutions to develop that are commercially viable.
  - b. Savers must be incentivised, not penalised.

*Q. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?*

13. If the Government is looking to individuals to meet more of their care costs then it is important that the system incentivises, and does not penalise, savers. In our most recent report we highlight that the current means testing system for social care could act as a disincentive to saving, in particular for those with assets between £20k and £40k. For every £1 they save, 80p of means test benefits will be lost. The new thresholds set out in the Care Act provide a greater level of reward for savers with this dropping to 50p for every additional £1 saved.<sup>9</sup>
14. We therefore suggest that should the Committee recommend a means-tested approach that it considers the impact on savers. One solution could be the introduction of a new category of financial products that allow savings to be exempt from the means test up to a specified

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<sup>8</sup> IFoA (2012) *Long term care: A review of global funding models* [Available online: <https://www.actuaries.org.uk/documents/long-term-care-review-global-funding-models-0>]

<sup>9</sup> IFoA (2015) *How financial products can work alongside the Care Act 2014 to help people pay for care* [Available online: <https://www.actuaries.org.uk/documents/how-financial-products-can-work-alongside-care-act-2014-help-people-pay-care-december-2015>]

threshold. This cost could be met by removing existing loopholes to the financial assessment that allow a person to qualify for means testing benefits whilst having significant assets saved. The kind of products in scope (to the extent they are used or earmarked for health and social care costs) would potentially be pension savings, ISAs, equity release from property and any new products which may come from market innovation e.g. disability-linked annuities. Tax incentives for personal saving for health and social care needs could also be considered, for example, allowing withdrawals from pension saving to be tax free if used for such health or social care needs.

15. We also suggest that before the Committee recommends a Dilnot-style cap continues to be pursued, that it also recommends that an assessment be completed on the level at which the cap is set, to determine what proportion of the population is likely to benefit, as well as the potential overall cost to the Exchequer. It should also be made clear what costs the cap covers to avoid any misunderstanding amongst the public. Our research on the Care Cap legislated for in the Care Act 2014, found that for individuals entering care at age 85 (typical age) around 8 percent of men and 15 percent of women would benefit from the cap, and that on average they would have spent £140,000 before reaching the '£72,000 cap'.<sup>10</sup>
16. Should the Committee wish to either explore the means-tested or care cap approach in further detail we would welcome the opportunity to discuss our work. We plan to complete further analysis on the impact of different thresholds and this may be of interest to the Committee as part of this inquiry.

### **Digitisation, big data and informatics**

*Q. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?*

17. As many actuaries price and reserve for insurance products, we have drawn from our experience in the insurance sector. Experience from overseas shows that technologies such as telehealth and wearables can encourage healthier living. In the US, the insurance sector is already using wearables to promote healthier living. One example is Blue Shield: Wellvolution, a non-profit insurer based in California. This scheme assigns challenges to employees that they earn points for completing and as a result, amongst its 5,000 employees, it has seen a 50 percent reduction in smoking, hypertension has reduced by 66 percent and it has saved the employees \$3million per annum in insurance premiums.<sup>11</sup> Another example is Discovery Limited in South Africa. Its Vitality programme incentivises members to live healthier lifestyles by providing them with rewards for achieving specified health goals. Rewards include discounts on travel, healthy foods and leisure activities. This programme allows members to connect their wearables to their profile to collect data that assesses their progress towards earning points. This also enables a more granular assessment of risk and provides greater insight into a policyholder's morbidity and mortality risk. These benefits would be the same for health services.<sup>12</sup>
18. In addition, the use of wearables is creating efficiencies that could be equally useful in the health sector. Wearables are helping insurers to improve upon resource intensive and costly

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<sup>10</sup> IFoA (2015) *How pensions can help meet consumer needs under the new social care regime* [Available online: <https://www.actuaries.org.uk/documents/how-pensions-can-meet-consumer-needs-under-new-social-care-regime-full-report-updated>]

<sup>11</sup> <https://www.blueshieldca.com/bsca/about-blue-shield/careers/wellvolution/incentives.sp>

<sup>12</sup> IFoA (2016) *Wearable technology: A health and care actuary's perspective* [Available online: <https://www.actuaries.org.uk/documents/wearable-technology-health-and-care-actuaries-perspective>]

underwriting practices. Access to the continuous picture of a policyholder's health can reduce inconvenience to policyholders and provide the potential for insurers to digitally streamline their underwriting process, reducing cost.<sup>13</sup>

19. Again, as with funding, linking with employers could be beneficial. Here in the UK, Havenrock Group's income protection scheme for its employees incorporates wearables to improve employee health. Insured employees get a free activity tracker and a free annual health check-up at their workplace. Data from these are combined on an online health portal that offers employees advice, annual reports and notification of any health issues they might wish to seek medical advice for. The employer also benefits from an anonymised overall annual health status report on its employees. It has seen improvements in productivity and reduced stress, fatigue and absenteeism.<sup>14</sup>

20. The greater use of wearables will not be without its challenges. A significant amount of analytical work is required to turn the data from healthcare wearables into meaningful rating factors to incorporate into estimates of morbidity or mortality. This will be made more complex by the interaction of multiple factors in determining someone's risk profile. However, the benefits of better estimates of morbidity and mortality could have significant cost saving for health and care services by enabling better targeting to high-risk groups / areas. Social care demand is increasing: better targeting of services could help increases in healthy life expectancy to catch up with increases in overall life expectancy, thereby reducing the demand and ultimately the cost of providing care.

Should you wish to discuss any of the points raised in further detail please contact Rebecca Deegan, Policy Manager ([rebecca.deegan@actuaries.org.uk](mailto:rebecca.deegan@actuaries.org.uk) / 02076322125) in the first instance.

Yours sincerely



Charles Cowling  
**Policy and Public Affairs Committee, Institute and Faculty of Actuaries**

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<sup>13</sup> *ibid*

<sup>14</sup> *ibid*