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Long-Term Care for the Elderly: Challenges and Policy Options

Policy reforms in long-term care will require methods to contain costs, to fairly divide these costs between care recipients and taxpayers, and to get more value for money in a sector that will feature prominently in future health policy debates.

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THE STUDY IN BRIEF

As Canada's society ages, more personal care and health support will be needed for people who, either as a consequence of disability or aging, require assistance to function independently. As this happens, policymakers face the daunting challenge of balancing the fiscal burden on taxpayers with the need to ensure that all individuals with long-term needs receive proper care. But this is a challenge best confronted immediately, before the first wave of babyboomers begins to draw heavily on long-term care programs in about 15 years' time.

In light of this challenge, policymakers must tackle two major policy questions. First, should governments take more responsibility for financing long-term care to bring this part of the healthcare system closer to the principle of universal coverage that currently applies to physician and hospital services? In other words, what are the right shares of public and private coverage in long-term care? Second, how could governments fund long-term care more efficiently, to get better value for the increasing amount of money they allocate to such care and to reduce costs in the healthcare system as a whole?

In an environment where tax rates are projected to rise because of demographics and growing health costs, the cost to the economy from raising additional tax revenue will be high. For this reason, we believe that the bulk of subsidies for long-term care services should go to those who lack the means to pay for it. This means that public subsidies would diminish with individuals' ability to pay – defined so as to reflect both income and, at least to some degree, assets as well. Such a targeted system of benefits could be designed so that the public gets more out of each dollar spent on long-term care services.

Reforms should insist on measures that eliminate the waiting lists that currently exist for many services and improve the location of care around patients' preferences. Following the examples of some European and Nordic countries, provinces are more likely to get better value for money if they channel more subsidies for long-term care to patients – in the form of cash or vouchers – rather than directly to the suppliers of services. This would allow patients a greater role in choosing among competing suppliers, including the option of using vouchers for home care or other services rather than for institutional care. A well-designed voucher system would, however, need to overcome legitimate concerns that it would increase total cost and that the quality of care could be at risk because elderly individuals might not be well informed about their best options for care.

Policy reforms in long-term care will require methods to contain costs, to fairly divide these costs between care recipients and taxpayers, and to get more value for money in a sector that will feature prominently in future policy debate.

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As the share of the elderly in Canada's population rises over the next several decades, and the demand for healthcare services expands, the cost of paying for their healthcare will present provincial governments with a major fiscal challenge.

Under the *Canada Health Act* (CHA), provinces pay the full cost of the physician and hospital services their residents require. But the CHA does not apply to two other components of aggregate healthcare costs that are important for many elderly: out-of-hospital drug costs, and non-acute care provided in long-term-care hospitals, nursing homes, or in patients' own homes. Instead, users pay a substantial part of these costs. While all provinces have programs that pay most of the costs the elderly incur for prescription drugs, for long-term care (LTC) the picture is mixed. Some provinces pay most of the costs of a wide range of LTC services, but others make patients pay a larger share of the costs and cover fewer services.¹

In this *Commentary*, we focus on two major policy questions of this increasingly important healthcare issue. First, should governments take more responsibility for financing long-term care to bring this part of the healthcare system closer to the principle of universal coverage that currently applies to physician and hospital services?

Second, how could governments fund long-term care more efficiently, to get better value for the increasing amount of money they allocate to such care and to reduce costs in the healthcare system

as a whole? Should providers be mostly public or private? How should they be paid? And how could better integrating long-term care with hospital and physician services improve the quality of the health system?

Whatever governments decide, they should act quickly: the time to deal with looming demographic pressures is now, before the first wave of baby boomers begins to demand high levels of long-term care in about 15 years' time.

To preview our main conclusions, we recommend a stronger role for provincial governments in guaranteeing access to long-term care for those who need it through a system of targeted subsidies available to those who cannot afford to pay for it themselves. The level of subsidies for public long-term care should be tuned to an individual's income and assets, with special mechanisms to protect the assets of a spouse who remains in the community while the other spouse is in long-term care. However, provinces that reduce public subsidies by one dollar for each additional dollar of income or assets should consider lowering income-based clawbacks, as these reduce an individual's incentive to save for future needs.

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1 The case for an increased government role in the funding of outpatient drugs has been eloquently made on many occasions, notably by the National Forum on Health and in the reports of the Romanow and Kirby commissions (see Kirby 2002; and, Romanow 2002). The federal government has also been urged to take some kind of initiative to incorporate universal protection against the burden of high drug costs into provincial health insurance plans.

With respect to the issue of value for money, the provinces should aim to free up hospital beds used by those waiting for home- or facility-based long-term care and thus eliminate the waiting lists for long-term care that currently plague the health system. This could be accomplished by better integrating the use of long-term-care resources and the provision of acute- and primary-care services, and by making a greater effort to meet the demand for long-term care. The provinces could, for example, put more emphasis on cash or voucher subsidies to patients, in place of the current arrangements under which most long-term care is directly provided to patients – commonly known as in-kind delivery. In many European countries, voucher systems have encouraged more direct competition for patients among providers and improved patients' satisfaction with their care.

POPULATION AGING AND THE RISING DEMAND FOR LONG-TERM CARE IN CANADA

Most people who need long-term care have health problems that make it difficult or impossible for them to perform the basics of daily living: dressing, eating, getting around, toileting, hygiene, and so on. Many are disabled because of injuries or strokes, but increasing numbers have deteriorating chronic diseases and conditions related to aging.

Although many long-term care patients need some of the same services as those in acute care, the process of providing long-term care has certain

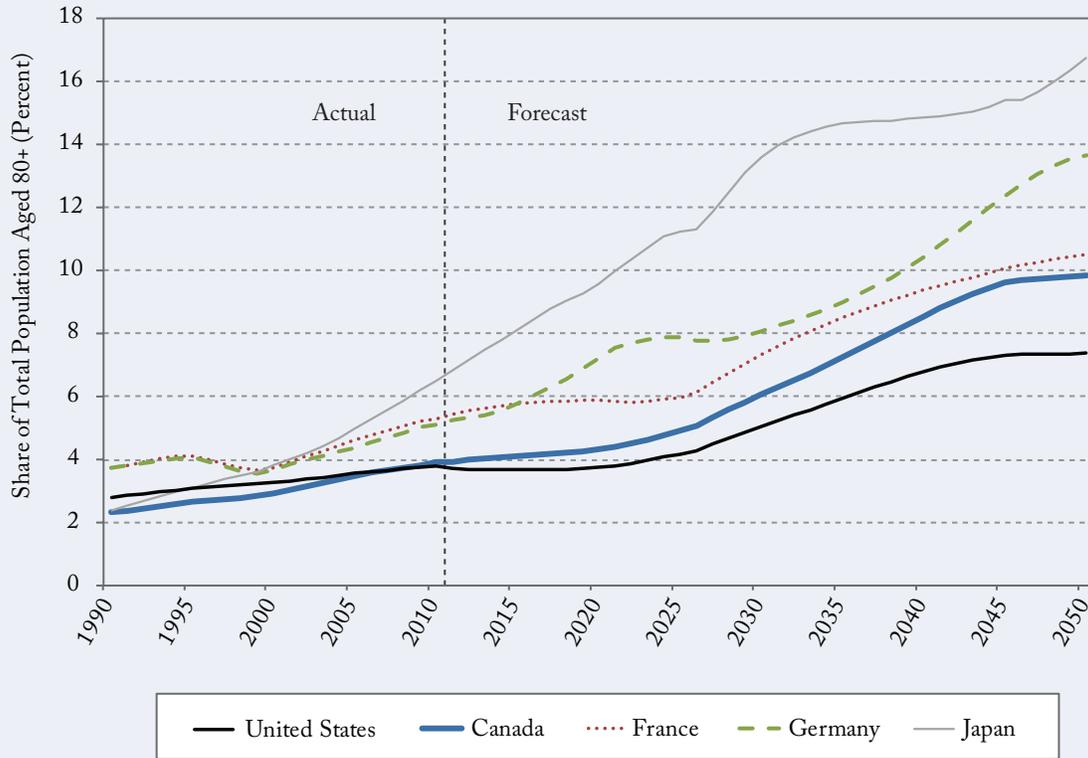
special characteristics that are relevant for policy. “Acute care” typically refers to care stemming from health problems that, in the absence of treatment, could quickly result in death or severe pain or disability, and from which the patient has a good chance to recover. “Long-term care,” in contrast, is for patients with chronic, and even irreversible, illness or disability – often, the principal goal of long-term care is not to cure but to improve the quality of a patient's remaining life.²

Most of those who need long-term care are the elderly. On average, in member countries of the Organisation for Economic Co-operation and Development (OECD), the proportion of those who need institutional or home care for chronic conditions is about 7 percent at age 65 but rises sharply to about 50 percent for those age 80 or older (OECD 2011).³ Canada will see its share of the “oldest-old” population – those age 80 and over – increase from roughly 4 percent in 2011 to 10 percent by 2050 (Figure 1). Although Canada's population will not age quite as rapidly as that in many other advanced countries, its long-term care needs nevertheless will increase dramatically.

The projections also imply that the working-age population, which finances and provides most long-term care, will not keep pace with the rising old-age population. The pressures on future workers to finance long-term care can be gauged by the dependency ratio of the oldest-old to those in the workforce,⁴ which is set to rise rapidly in this country. The Atlantic provinces will see dependency ratios double by 2030 and triple by 2050, and even

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- 2 The provinces use an assortment of names and terms to define the range of interventions that can be classified as “long-term care” or “continuing care.” See Canadian Healthcare Association (2009, appendix A) for a comprehensive presentation of the types of long-term care.
 - 3 There is some debate about the effect on morbidity rates if babyboomers should prove healthier in old age than were past generations of elderly (Denton and Spencer 2010), but the strong correlation between an individual's age and the risk of chronic health conditions nevertheless will remain.
 - 4 This demographic metric has also been used to demonstrate there will be supply shortages of caregivers relative to demand. Although it is clear that this will be a pressing issue for long-term care in the future, it is beyond the scope of this *Commentary*. See Hicks (2012) for more on these demographic and labour force trends.

Figure 1: Share of Total Population Age 80+, Canada and Selected OECD Countries, 1990–2050



Source: OECDStat (2012).

where the population is somewhat younger, as in Ontario, Quebec, and the West, the ratio will more than double over the next 40 years (Table 1). This aging trend is present in almost all other OECD countries, whose spending on long-term care is projected to double, or even triple, over the next 50 years (OECD 2011).⁵ For Canada, some estimates suggest that the cost over the next 35 years will be \$1.2 trillion, an increasing share of which is projected to be borne by private individuals (CLHIA 2012).

Advance planning for the long-term-care sector is important not only to deal with future cost pressures in the sector itself, but also because of the interaction between long-term care and the regular acute-care system. One major consequence of the current long-term-care system concerns “alternate level of care” (ALC) patients – those in acute-care hospitals who could be cared for in lower-level residential facilities such as nursing homes, or at home with extensive support. Today, much like in prior years where data on ALC patients are publicly

5 Some analysts argue that morbidity rates among the elderly are likely to fall thanks to healthier lifestyles among current workers, but this effect is unlikely to offset the pressures of an aging population or to prevent the eventual onset of chronic conditions, which drive long-term-care needs.

Table 1: Very-Old Dependency Ratio (Ages 80+/18-64), Provinces and Territories, 2010-2050

| Jurisdiction | Actual | Forecast | | | | 2010 to 2050 Increase (percent) |
|--------------|--------|----------|------|------|------|---------------------------------|
| | 2010 | 2020 | 2030 | 2040 | 2050 | |
| NL | 5.6 | 7.4 | 14.2 | 21.5 | 24.5 | 338.1 |
| PE | 6.4 | 7.3 | 11.8 | 16.0 | 18.2 | 183.6 |
| NS | 6.7 | 7.7 | 13.3 | 19.3 | 22.0 | 226.6 |
| NB | 6.8 | 7.4 | 12.1 | 18.9 | 22.6 | 234.9 |
| QC | 6.5 | 7.3 | 11.6 | 16.3 | 18.3 | 182.0 |
| ON | 6.0 | 6.4 | 9.5 | 13.8 | 16.8 | 178.4 |
| MB | 6.7 | 5.9 | 8.3 | 11.4 | 12.3 | 84.9 |
| SK | 7.3 | 6.6 | 8.8 | 12.5 | 13.6 | 86.1 |
| AB | 4.4 | 4.5 | 7.3 | 11.8 | 15.0 | 241.3 |
| BC | 6.5 | 7.0 | 11.0 | 15.9 | 18.5 | 183.6 |
| NT | 1.3 | 2.8 | 7.0 | 10.1 | 11.0 | 780.0 |
| YK | 1.6 | 2.4 | 5.4 | 7.2 | 2.8 | 77.1 |
| NU | 0.5 | 1.3 | 2.6 | 3.8 | 4.2 | 790.4 |

Sources: Statistics Canada and authors' calculations.

available, many patients classified as no longer requiring acute care but awaiting discharge or transfer often spent extended periods in hospitals, occupying beds that could otherwise have been used by patients with acute problems (Figure 2).⁶

LONG-TERM CARE: HOW MUCH AND WHO PAYS?

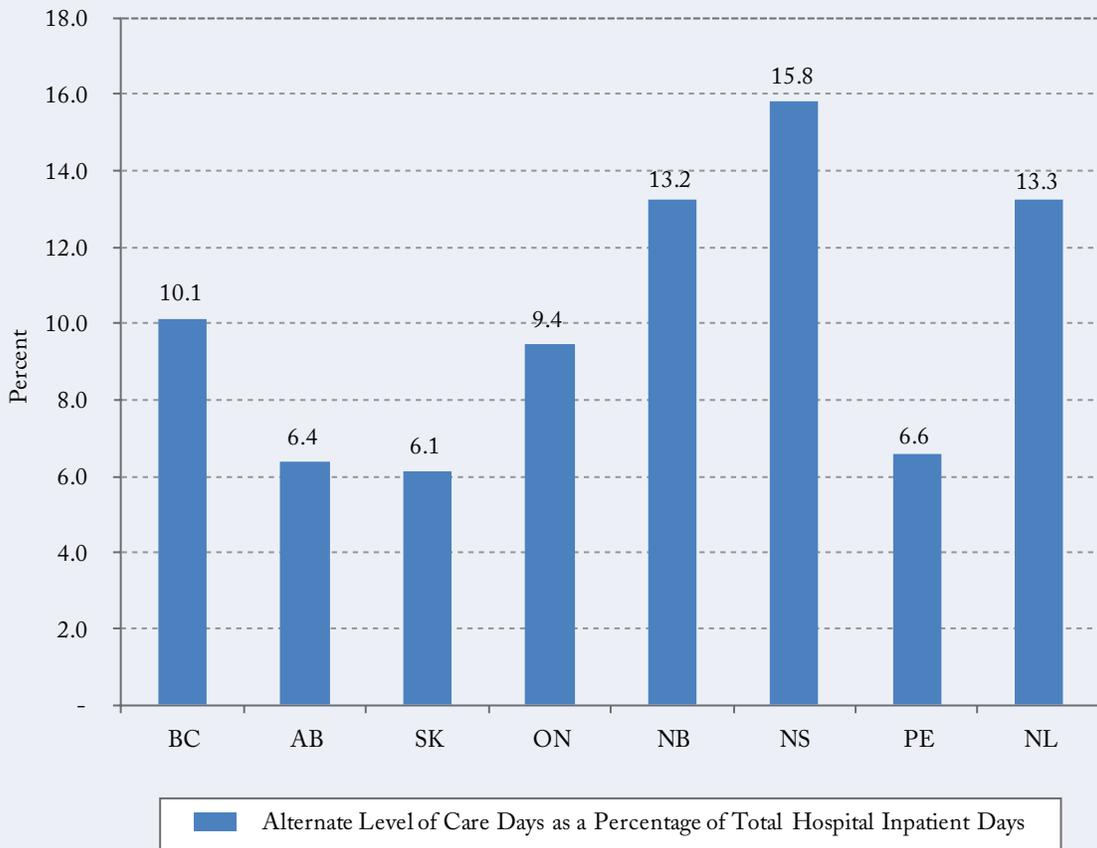
Most Canadians would agree that government should take some responsibility for financing long-term care, but views vary widely on what its

exact role should be. At one end of the spectrum are those who hold that government's role should be limited to that of a last-resort backstop for those who cannot pay on their own (the "safety net model"). At the other end are those who favour a universal model in which government supplies highly subsidized long-term care, on the same terms, to all who need it.⁷ The main argument for government financing of long-term care for those with no means of their own is to fulfill society's obligation to ensure that all citizens can obtain

6 Importantly, the long-term-care bed-shortage problem is not restricted to individuals waiting in hospitals; many are waiting in their own homes for a nursing-home bed and might be receiving substandard care.

7 Grignon and Bernier (2012) present arguments for a publicly financed universal social insurance plan for long-term care.

Figure 2: Alternate Level of Care Days as a Percentage of Total Hospital Inpatient Days, by Province, fiscal year 2007/08



Note: No comparable data are available for Manitoba and Quebec. Around 60 percent of all ALC patients await transfer to a long-term facility. Source: CIHI (2009).

a minimum standard of care, regardless of their ability to pay. Indeed, all industrialized countries, including Canada and the United States, have government long-term care programs to ensure that this objective is met. The rationale for a universal program, however, is much less clear.

The economic theory of insurance tells us that the net benefits of insurance – in a community whose members are subject to the risk of financial loss – are likely to be large, first, when some individuals may suffer large losses and, second, when individuals regard it as important to protect their assets in order to maintain their standard of living even if a major loss occurs. General health insurance fits this description: universal, publicly funded health insurance is valuable, on this view,

not only because it guarantees that everyone in a community will have access to care even if they cannot pay for it themselves, but also because it protects all citizens against health-related financial risk as it pays for health services that they would otherwise have to pay for out of their own pockets.

The need for costly long-term care also varies highly from one individual to another. Many people are able to function normally throughout their old age, and die after only a brief illness. But a substantial number will suffer from serious and disabling chronic illness – mental, physical, or both – and require long-term care at a cost that could easily deplete the assets of all but the wealthiest.

Two major aspects of long-term care make the implicit financial risk associated with it different,

however, from that of costly acute-care episodes: most long-term care is supplied to people who are elderly, and most episodes of long-term care do not lead to recovery, but end with death.

Together, these two aspects imply that the value to individuals in long-term care of protecting their assets might not be as great as it is for those in acute care: For elderly people who are not going to be restored to normal health, the objective of protecting their future standard of living will not be as urgent as for younger people in acute care for whom a rapid loss of wealth could dramatically impact their quality of life even if they return to good health.

Because most long-term care recipients are elderly, the public funding of long-term care is also relevant in terms of the extent to which the net benefit of taxation and government expenditure is equitable across different generations. Introducing a costly program of universal subsidies for long-term care today would add to the already heavy burden that working-age taxpayers will face in paying for existing healthcare and retirement-benefit programs for the increasingly numerous elderly in coming decades. In Canada, this demographic crunch is already causing a heavy fiscal burden. Robson (2010) estimates this country's future healthcare obligations, in terms of the implicit unfunded liability of today's governments, at roughly \$2.7 trillion, on top of existing recorded debt. Committing future Canadian taxpayers to paying a larger share of long-term-care costs received by the elderly would add further to this total.

To us, this is a strong argument against universal government funding of long-term care and in favour of a less ambitious approach of subsidies targeted at those who need them the most. Alternatively, it is an argument in favour of arrangements that shift more of the financing burden to future recipients of long-term care, through compulsory contributions to a social insurance fund (like the Canada Pension Plan approach to retirement savings) or through a

scheme under which payments for past long-term care are made out of assets a person leaves behind at death.

HOW DO WE GET THE MOST VALUE FOR LONG-TERM CARE MONEY?

Whether government programs to subsidize long-term care are universal or means tested, an important public policy objective is to encourage cost-effective use of resources in both the long-term-care sector and in the healthcare sector as a whole. One obvious condition necessary to meet this objective is that long-term care patients not be kept in acute-care hospital beds if they can be cared for in a less expensive setting, such as in a nursing home, in their own home with the help of outside providers, or elsewhere in the community. Moreover, long-term care services may be produced by private firms, profit or non-profit, or in firms owned by government itself, and they may be paid for in different ways. Public policy must consider what producers and long-term care services offer the best value for money, and design the regulations and incentives that govern their use accordingly.

Institutional or Community-based Care?

Perhaps the most important change in the nature of long-term care programs in recent decades has been the expansion of subsidized care provided in patients' homes (CIHI 2005, 91). This trend has been evident not just across Canada but in many other countries as well. Home-based care – or, more generally, care provided “in the community,” rather than in institutions – has expanded partly because it was hoped that it would save costs, but partly in response to patients' and families' preferences. The effect of the shift in these two areas, however, depends to a great extent on how programs are designed, including the criteria as to who is eligible for what level of benefits.

The degree to which increasing the amount of resources spent on community care makes possible

a reduction in the aggregate costs of long-term care, or of healthcare in general, has been the subject of a large amount of empirical research (see, for example, Hollander 2002; and OECD 2011). In considering this issue, one must take into account that the total cost of institutional care includes not only health services, such as those of nurses and physicians, but also accommodations and food, which patients cared for in their homes would pay for out of their own pockets. Further, family members might need to take time off work to provide care to loved ones, which also adds to private long-term care costs.

For patients who need a large amount of nursing and physician care, the per-patient cost of such services might be lower in an institution than in patients' homes. Thus, in determining what share of the costs subsidized patients in institutions should pay, provincial governments should take any such cost difference into account so as to provide an appropriate incentive for patients to choose where to receive their care in a way that reflects not only their individual preferences, but also the cost of publicly funded health services that are paid for out of provincial plans.

The cost to governments of long-term care also will be influenced by what options patients are offered when they need such care. In Canada, the criteria used to determine eligibility for different types of subsidized care, and how they are applied in individual cases, differ from province to province. Although transparent and clearly defined rules are desirable, other things being equal, there is also a need for flexibility in the way they are applied, especially if attempts are made to control aggregate costs by making the criteria relatively restrictive. In practice, eligibility assessments would depend significantly on the judgment of family doctors or social workers familiar with individual cases, and tension will exist between these professionals' desire to help their patients or clients and the need to control costs by limiting the number of beneficiaries. When subsidized services are rationed and there are waiting lists for them, the length of these lists and the burden on those waiting also

depend partly on the stringency of the eligibility criteria and how they are applied.

Alternate Level of Care Patients in Acute-Care Hospitals

As noted earlier, many elderly patients who have been treated in hospital continue to occupy acute-care hospital beds even though they could be cared for in nursing homes or, with proper support, in the community. From society's point of view, the cost of keeping them in hospitals should be considered part of the cost of long-term care. Keeping ALC patients in acute-care hospital beds is wasteful both because the cost of their care in an acute-care hospital is likely to be higher than in a nursing home or in the community, and because it disrupts urgent acute-care services when there are not enough hospital beds. Measures to reduce the number of ALC patients in acute-care hospital beds, therefore, could contribute substantially to improved value for money in long-term care.

In the Canadian system, patients pay nothing out of pocket for any services they receive in hospital and thus have no financial incentive to leave even if they could be cared for elsewhere at a lower cost to society. Moreover, hospitals that are financed through global budgets that do not depend on the services they provide also have little financial incentive to discharge such patients even if the open bed would be filled immediately, perhaps with a patient with greater need. Reducing patients' incentive to stay in acute-care beds, by reducing their out-of-pocket costs in nursing homes or by allowing hospitals to charge ALC patients for room and board, might help reduce the extent of the ALC problem. That said, the latter would be a blunt instrument to deal with ALC patients, who may not have a clear understanding of the alternatives available to them. A more palatable option would be to increase the incentive for hospitals and their discharge planners to free up beds for patients with more urgent needs – for example, by moving toward case-based funding.

In most cases, however, the reduction of waiting lists for places in nursing homes or for long-term care in the community will require changes that encourage caregivers and providers to respond better to the pent-up demand for long-term care. These waiting lists are costly, not only because they contribute to the problem of expensive care in undesirable locations – long hospital stays while waiting for a nursing home bed – but also because they impose a burden on patients in the community, and their families, who need such services but must wait for them. Rationing access to long-term care by waiting lists implies not only a degree of inefficient use of economic resources but also a failure to attain high standards of transparency in public policy: It is difficult to defend a state of affairs in which official policy is to provide a set of benefits to specific population groups, but with no guarantee as to *when* these benefits will be available. Another option to help reduce waiting lists is to move away from a system that delivers services in kind toward one where patients are given public funds they can use, and supplement with their own resources, to access services from their provider of choice.

Subsidized Long-Term Care: Private or Government, in Kind or in Cash?

Another set of choices that can influence the value that society receives from the funds government spends on long-term care concerns by whom these services are produced and how suppliers are paid. In principle, long-term care can be supplied by firms that are owned and managed by government, or by private firms, either for-profit or non-profit. In most countries, all three of these ownership forms – in addition to informal home care provided by family

and friends – are commonly represented. Private markets for unsubsidized long-term care exist even in countries where government programs subsidize some patients. For example, individuals with health problems that cause them difficulties with daily living may elect to buy home care services privately even if their problems are not severe enough to make them eligible for a subsidy. Similarly, elderly individuals with high income may choose to live in a retirement home that supplies nursing care even if they have to pay the full cost out of their own pocket. In such private markets, the fees providers charge can be market-determined, via offers from competing sellers. In contrast to the case of many acute-care services, private markets for long-term care in which patients make choices among such offers might work reasonably well, since the buyers in these markets typically do not need as much specialized and technical information to evaluate the quality of the services they buy as they would in a competitive private market for most acute-care services.⁸

In principle, long-term care can be supplied at fees determined by market competition, even when there are government programs for the financing of care for certain population groups. In a program under which government supplies privately produced services to subsidized patients in kind, government buys these services from private providers. This is the model most frequently used in Canada today. Under this model, the government fixes the co-payments – out-of-pocket costs – that patients must make, but the fees providers receive are market-determined in the sense that they are negotiated between the providers and government, and the extent of the subsidy to each patient is determined as a residual.

8 For elderly patients with cognitive problems, market choices typically must be made by people acting on their behalf, usually family members or social workers. Thus, McGregor and Ronald (2011), among others, have advocated for resources, such as an online registry of providers' records of compliance with regulations, to make it easier to compare providers.

In an alternative model, subsidies are paid in accordance with the principle of patient-based funding.⁹ Under this principle, the amount of subsidy patients receive can depend on their classification in terms of the degree of their disability, and possibly their incomes and assets, but patients are free to choose among competing private providers, who may differ in the fees they charge for given categories of patients and who may supply services to both subsidized and unsubsidized patients. Under such a system, the patient receives a fixed subsidy up front, which does not depend on the fee the provider charges. The patient's co-payment is then determined as a residual by the difference between what the service provider charges and the amount of the subsidy; the co-payment thus differs from one provider to the next if they charge different fees. With subsidized patients able to choose their provider of services, such a system is equivalent to a voucher system or a cash subsidy.

There are good reasons for and against each of these options. From the viewpoint of patients and their families, an advantage of the in-kind model with a fixed co-payment is that there is more financial certainty about the costs of long-term care but correspondingly less flexibility and patient choice. For government, provision in kind offers it an opportunity to reduce costs by exercising its market power as a large buyer of services, or by efficient management if the services are produced by government itself. It also might offer better control over the kinds and quality of services that are supplied.

At the same time, the problems associated with rationing and waiting lists are more likely to arise

when services are supplied in kind. On balance, we believe a move toward more reliance on subsidies in vouchers or cash would improve the value for money in LTC.

LONG-TERM CARE IN CANADA: THE CURRENT PICTURE

Canada's provinces and territories differ substantially in the extent to which they subsidize long-term care and in the methods they use to ensure good value for the money spent on it. Traditionally, government support has gone principally to individuals in licensed institutions such as nursing homes. In recent years, however, the supply of long-term care in the community has expanded for adults living at home and those in adult daycare and assisted daily living facilities. In responding to this trend, each province has developed a unique array of subsidized programs that vary in ease of access and availability of services.

Financing: Targeted Universalism

The provinces subsidize long-term care out of general revenues through a modified, non-universal safety-net model that is sometimes referred to as "targeted universalism" (OECD 2011). All offer needs-based programs that are universal in the sense that they are available to all residents who meet the needs-tests criteria. These programs, however, are targeted in the sense that recipients' co-payments are means tested: In defining recipients' ability to pay their share, all provinces and territories take into account their declared income – indeed, Quebec and Newfoundland and Labrador also include assets.¹⁰

9 To date, patient-based funding is being implemented, to different degrees, only in Ontario and Alberta.

10 Historically, many Canadian provinces set private long-term care charges based upon both assets and income, but most have since changed this to include only income. A main reason for this was concern over the burden of private fees on families with one person in residential care with a spouse still living in the community (Stadnyk 2009).

Setting the Public and Private Shares

In deciding on the subsidy for recipients of long-term care, provinces and territories distinguish between funding for what is referred to as “direct” services – case management, nursing care, physicians, and so on – and the associated charges for shelter, food, and housekeeping. In principle, individuals’ co-payments are intended to cover all or part of the costs of living that recipients would be paying in any case if they still lived in the community.¹¹ Patients staying in a licensed government-subsidized residential facility or using subsidized homecare services must pay these co-payment costs out of pocket or through private supplementary insurance – although, despite its availability, the latter is somewhat of a niche product in Canada, with only about 1 percent of Canadians age 65 and older currently owning private long-term care insurance (OECD 2011).

Average private charges for subsidized facility-based care tend to rise as one moves eastward (Table 2). In each province, minimum private facility-based costs are closely integrated with the federal public income-support system for seniors. For single individuals and couples, minimum facility-care fees are set according to Old Age Security (OAS) and Guaranteed Income Supplement (GIS) maximum monthly payments. Each individual living in a residential facility is also entitled to a minimum monthly allowance for personal expenses. Those with incomes greater than basic OAS/GIS levels face a clawback of their subsidy – that is, they must pay higher facility fees, up to a specified maximum. In most provinces, the clawback rate is 100 percent, meaning that patients must pay an additional dollar in fees for each dollar of income above the basic OAS/GIS threshold.

Alberta and Newfoundland and Labrador illustrate the variation in approaches to private long-term care charges. In Alberta, a single individual receiving care in a subsidized institution pays a maximum of roughly \$16,200 annually out of his or her own pocket as a facility fee, reduced to about \$11,000 if the individual’s income is limited to federal OAS/GIS transfers; any income above the old-age federal income support cutoff is clawed back, generally at around 100 percent, until the maximum charges are paid in full. In Newfoundland and Labrador, a single individual in institutional care pays a maximum of roughly \$33,600 annually towards facility charges, reduced to around \$13,500 annually if the individual’s income is limited to federal OAS/GIS transfers and his or her assets do not exceed \$10,000. Incomes above the federal old-age income maximum or assets above \$10,000 normally are assessed at 100 percent, meaning that every additional dollar of earnings goes directly towards additional charges. Notably, the territories, in contrast to the provinces, charge a flat, universal fee for facility-based long-term care.

Although most provinces assess income above OAS/GIS transfers at 100 percent until the maximum co-payment is reached, Saskatchewan claws back only 50 cents on every additional dollar above the OAS/GIS level until the maximum is reached, allowing residents of that province who need facility-based long-term care to keep a larger share of their income. It also reduces an unintended incentive that many middle-income seniors face under the current approach to income testing in most provinces: to deplete their income-yielding assets fully or pass them on to their heirs before going into a long-term care facility, to avoid dollar-for-dollar clawbacks.

11 The Canadian Healthcare Association has been rightly critical that this principle is not strictly followed in practice – that residential care fees sometimes are set above true accommodation costs (CHA 2009).

Table 2: Private Charges for Government Subsidized LTC Services, By Jurisdiction

| | | Facility-Based Care | | | | | Home Care | |
|-----------|--|--|---|------------------|---|------------------|--|------------------|
| | | Conditions on Government Subsidy for Private Charges | | | | | | |
| Provinces | | (\$ annual) | Single Individual | Asset Deduction? | One Spouse in Care | Asset Deduction? | Government Subsidy Available? | Asset Deduction? |
| BC | Regular charges | 36,200 | Reduced charges apply when: OAS/GIS max < annual income < \$37,000. Income > OAS/GIS max but < \$19,500 assessed at 100%. Income > \$19,500 assessed at 80% until ~\$50,000. | No | Same formula applies to split income. If spouse in care has higher income than other spouse, higher charges will apply. Spouses in community can retain reasonable income. | No | No income test; Income-tested subsidy is available. | No |
| | Reduced charges | 11,200 | | | | | | |
| | Minimum annual allowance for residents | 3,900 | | | | | | |
| AB | Regular charges | 16,200 | Reduced charges apply when: OAS/GIS max < annual income < \$24,600. Income above OAS/GIS max assessed at ~100% until \$24,600. | No | Reduced charges apply when: OAS/GIS max < annual joint income < \$40,000. Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max. level. | No | No income test; Income-tested seniors benefit available. | No |
| | Minimum charges | 11,000 | | | | | | |
| | Minimum annual allowance for residents | 3,180 | | | | | | |

| Table 2: Continued | | | | | | | | |
|---------------------|--|--|---|------------------|---|------------------|---|------------------|
| Facility-Based Care | | | | | | | Home Care | |
| | | Conditions on Government Subsidy for Private Charges | | | | | | |
| Provinces | | (\$ annual) | Single Individual | Asset Deduction? | One Spouse in Care | Asset Deduction? | Government Subsidy Available? | Asset Deduction? |
| SK | Regular charges | 22,900 | <p>Reduced charges apply when: OAS/GIS max < annual income < \$37,000. Income above OAS/GIS max assessed at 50% until \$37,000.</p> <p>Assessment based on gross income.</p> | No | <p>Same formula applies to half of joint family income.</p> <p>Assessment based on half of joint gross income.</p> | No | No income test; Income-tested subsidy is available. | No |
| | Minimum charges | 12,100 | | | | | | |
| | Minimum annual allowance for residents | 2,544 | | | | | | |
| MB | Regular charges | 26,800 | <p>Reduced charges apply when: OAS/GIS max < annual income < \$15,000. Income above OAS/GIS max assessed at 100% until \$30,100.</p> <p>Assessment based on gross income.</p> | No | <p>Reduced charges apply when: \$45,000 < annual income < ~\$60,400. Family income above \$45,000 assessed at 100% until ~\$60,400.</p> <p>For those paying the minimum charges, partner allowed to retain at least \$18,000 for living expenses.</p> <p>For those paying above the minimum charges, partner allowed to retain at least \$30,240 for living expenses.</p> | No | No income test. | No |
| | Minimum charges | 11,400 | | | | | | |
| | Minimum annual allowance for residents | 3,324 | | | | | | |

Table 2: Continued

| | | Facility-Based Care | | | | | Home Care | |
|-----------|--|--|---|--|--|---|--|------------------|
| | | Conditions on Government Subsidy for Private Charges | | | | | | |
| Provinces | | (\$ annual) | Single Individual | Asset Deduction? | One Spouse in Care | Asset Deduction? | Government Subsidy Available? | Asset Deduction? |
| ON | Regular charges | 19,400 | Reduced charges apply when: OAS/GIS max < annual income < \$15,000. Income above OAS/GIS max assessed at 100% until \$21,000. Assessment based on net income. | No | Reduced charges apply when: OAS/GIS couple max < annual income < ~\$57,000. Family income above OAS/GIS max, plus reasonable living allowance for spouse in community, assessed at 100% until ~\$57,000. Assessment based on half of joint net income. Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max. level. | No | No income test. | No |
| | Minimum charges | 12,600 | | | | | | |
| | Minimum annual allowance for residents | 1,560 | | | | | | |
| QC | Regular charges | 12,800 | Assuming no assets, reduced charges apply when: OAS/GIS max < annual income < \$15,000. Income above OAS/GIS max assessed at 100% until \$15,000. Assessment based on gross income. | Yes, clawbacks for assets kick in when income > \$40,000 | Assuming no assets, reduced charges apply when: OAS/GIS single max < annual family income < ~\$67,000. Family income above OAS/GIS single max. assessed at 100% until ~\$67,000. Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max. level. | Yes, clawbacks for assets kick in when income > \$40,000. | Most home care costs covered. Income assessments may reduce private charges for some home care services (i.e. housekeeping, meal delivery, home repairs).. | Yes |
| | Minimum charges | 10,400 | | | | | | |
| | Minimum annual allowance for residents | 2,268 | | | | | | |

| Table 2: Continued | | | | | | | | |
|--|--|-------------|---|------------------|--|------------------|--|------------------|
| Facility-Based Care | | | | | | Home Care | | |
| Conditions on Government Subsidy for Private Charges | | | | | | | | |
| Provinces | | (\$ annual) | Single Individual | Asset Deduction? | One Spouse in Care | Asset Deduction? | Government Subsidy Available? | Asset Deduction? |
| NB | Regular charges | 30,300 | <p>Reduced charges apply when: OAS/GIS max < annual income < \$31,500. Income above OAS/GIS max assessed at 100% until \$31,500.</p> <p>Assessment based on net income.</p> | No | <p>Reduced charges apply when: OAS/GIS single max < annual family income < ~\$67,000. Family income above OAS/GIS single max. assessed at 30, 80, and 100% until ~\$67,000.</p> <p>Assessment based on net family income.</p> <p>Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max. level.</p> | No | <p>Income assessment may reduce private home care charges.</p> <p>Income assessment based on family composition and annual income. Income is assessed at 100% for singles earning over \$25,000; \$35,000 for couples.</p> | No |
| | Minimum charges | 11,400 | | | | | | |
| | Minimum annual allowance for residents | 1,296 | | | | | | |
| NS | Regular charges | 36,100 | <p>Reduced charges apply when: OAS/GIS max < annual income < \$42,000. Income above OAS/GIS max assessed at 100% until \$42,000.</p> <p>Assessment based on net income.</p> <p>Residents can request lower level of care at max of \$22,300 annually.</p> | No | <p>Reduced charges apply when: OAS/GIS couple max < annual income < ~\$84,000. Family income above OAS/GIS max, plus reasonable living allowance for spouse in community, assessed at 100% until ~\$57,000.</p> <p>Assessment based on half of joint net income.</p> <p>Spouses in community can retain at least \$16,974/year. Means that minimum charges can fall below OAS/GIS single max. level.</p> | No | <p>Income assessment may reduce private home care charges.</p> <p>Income assessment based on grid that includes household size and annual income. Private charges have ceiling.</p> | No |
| | Minimum charges | 12,500 | | | | | | |
| | Minimum annual allowance for residents | 2,760 | | | | | | |

Table 2: Continued

| | | Facility-Based Care | | | | | Home Care | |
|-----------|--|--|--|--|--|-----------------------------------|---|---|
| | | Conditions on Government Subsidy for Private Charges | | | | | | |
| Provinces | | (\$ annual) | Single Individual | Asset Deduction? | One Spouse in Care | Asset Deduction? | Government Subsidy Available? | Asset Deduction? |
| PEI | Regular charges | 26,500 | Reduced charges apply when: OAS/GIS max < annual income < \$27,700. Income above OAS/GIS max assessed at 100% until \$27,700. Assessment based on net income. | No | Reduced charges apply when: OAS/GIS couple max < annual income < ~\$57,000. Family income above OAS/GIS max, plus reasonable living allowance for spouse in community, assessed at 100% until ~\$57,000. Assessment based on half of joint net income. Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max. level. | No | No income test. | No |
| | Minimum charges | 14,000 | | | | | | |
| | Minimum annual allowance for residents | 1,236 | | | | | | |
| NL | Regular charges | 33,600 | Reduced charges apply when: OAS/GIS max < annual income < \$35,100. Income above OAS/GIS max assessed at 100% until \$35,100. Assessment based on net income. | Yes, on liquid assets. \$10,000 limit for single indiv. | Reduced charges apply when: OAS/GIS couple max < annual income < ~\$75,000. Family income above OAS/GIS max, plus reasonable living allowance for spouse in community, assessed at 100% until ~\$75,000. Assessment based on half of joint net income. Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max. level. | N/A. Yes if both couples in care. | Income assessment may reduce private home care charges. Income assessed at different rates, up to 15 percent of total income, if: \$13,000 < income < \$150,000. Maximum subsidy (aged 65+) is \$32,952 per year. Annual exempted income is \$21,000 for couple. | Yes, on liquid assets. \$10,000 for single individual; \$20,000 for couple. |
| | Minimum charges | 13,500 | | | | | | |
| | Minimum annual allowance for residents | 1,800 | | | | | | |

Table 2: Continued

| Facility-Based Care | | | | | | Home Care | | |
|--|----------|-------------|--|------------------|--|------------------|--|------------------|
| Conditions on Government Subsidy for Private Charges | | | | | | | | |
| Territories | | (\$ annual) | Single Individual | Asset Deduction? | One Spouse in Care | Asset Deduction? | Government Subsidy Available? | Asset Deduction? |
| NT | Flat fee | 8,500 | No government subsidies as fee is set below OAS/GIS max. | No | No government subsidies as fee is set below OAS/GIS max for couples. | No | No private charge for homecare services. | |
| YK | Flat fee | 7,655 | No government subsidies as fee is set below OAS/GIS max. | No | No government subsidies as fee is set below OAS/GIS max for couples. | No | No private charge for homecare services. | |
| NU | Flat fee | no cost | | No | | No | No private charge for homecare services. | |

Sources: Fernandes and Spencers (2010); Manulife (2011); and miscellaneous government documents.

Over the past 15 years, a period of rapid government revenue growth, the provinces – Quebec and Newfoundland and Labrador excepted – have moved away from asset testing in determining the size of private long-term care charges. The change came in response to concern that strict asset clawbacks were not equitable for couples where one spouse was in care and the other was still in the community (Stadnyk 2009). The fear was that a province could end up forcing the spouse in the community to sell the family home and move to pay for private long-term care, an issue to which we return later in the *Commentary*.

Care Providers and Financial Flows

In Canada – in contrast to countries such as France, Germany, Sweden, Finland, and Denmark – the provision of subsidized long-term care is almost entirely in kind rather than in cash or vouchers. Patient co-payments for both home care and institution-based services are fixed, and the provincial government, not the patient, pays the residual costs of services supplied to subsidized patients. In some cases, home care is supplied through persons employed in government agencies, but more commonly governments contract with private firms to supply such services. Although some subsidized patients reside in provincially owned hospitals, many more are cared for in private nursing homes that derive their revenue from provincial government plans. Indeed, as Figure 3 shows, private for-profit, public, and private not-for-profit providers of government-subsidized

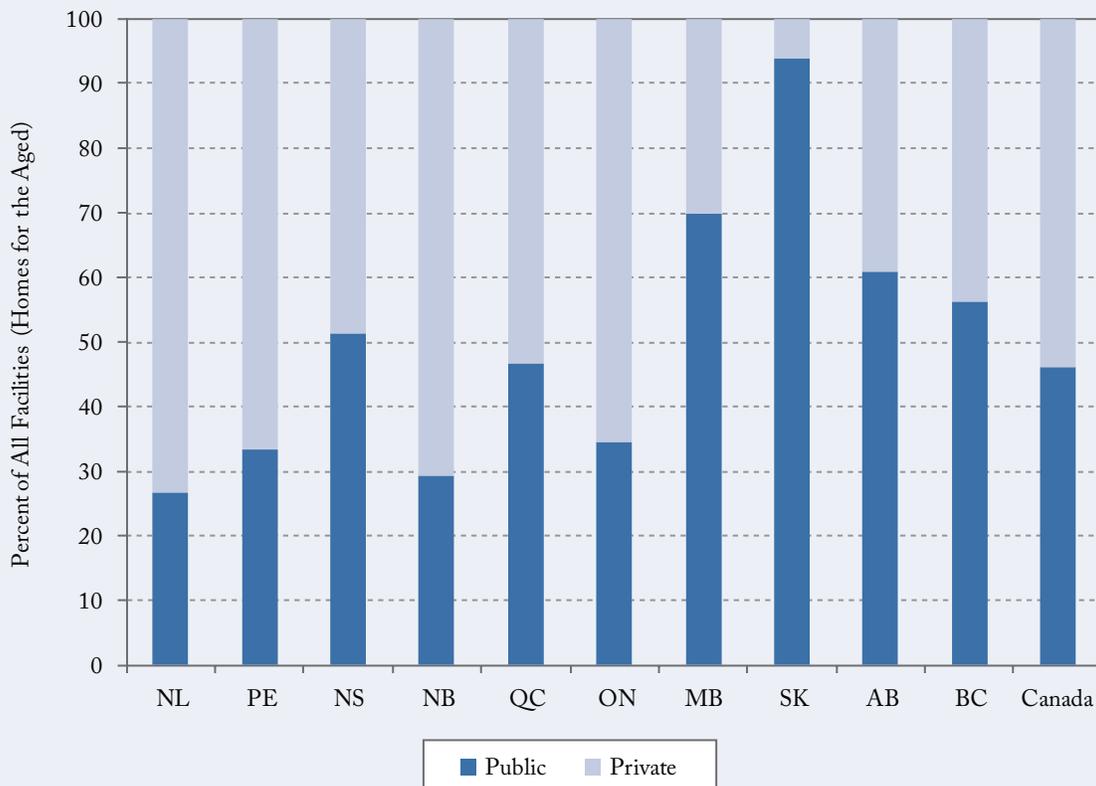
home care services and facility-based long-term care exist across the country, and, as Figure 4 reveals, for-profit providers play a reasonably large role in most provinces. Importantly, in contrast to Canada's acute-care system, Canadians may purchase unsubsidized, private, long-term care – many retirement homes, for example, are privately owned and operated, and control their own admissions, fees, and waiting lists, if any, without government intervention.

Financial and Service Flows in LTC

Figure 5 shows the direction of financial flows and service flows in provincial LTC systems. Subsidized LTC facilities receive two funding streams from government: one associated with nursing and direct health care services, and another for accommodation costs – such as lodging, housekeeping and maintenance – which, in principle, should equal the maximum private charges.¹² Nominal adjustments are made, however, to the size of the public subsidy to account for the patient's necessary level of care.¹³ The provinces are responsible for setting individuals' co-payments, which, as shown in Table 2, typically are reduced if a patient's income falls below a certain level, in accord with the principle of "targeted universalism." Governments sign contracts with providers on behalf of patients in long-term care, and some provinces allow for-profit and not-for-profit providers to compete for contracts under restrictive conditions. The provinces also regulate the quality and care conditions for the services patients receive.

-
- 12 Ontario, in particular, restricts nursing homes from using any of the money they receive for direct nursing and health support services from being allocated to the home's bottom line. In theory, money for these services must be returned to the government by the end of the year if not used.
- 13 Alberta and, to some degree, Ontario are moving toward activity-based funding for long-term-care facilities, where the money "follows the patient" – that is, the funds facilities receive are based on the patient's estimated need for care. One reviewer of this *Commentary* points out that the shortage of beds for long-term care is partly due to the shortage of the special beds that some patients require.

Figure 3: Ownership of Nursing Home Facilities: The Public/Private Mix, 2008



Source: Statistics Canada (2008).

Efficiency of Resource Use: Eligibility Tests

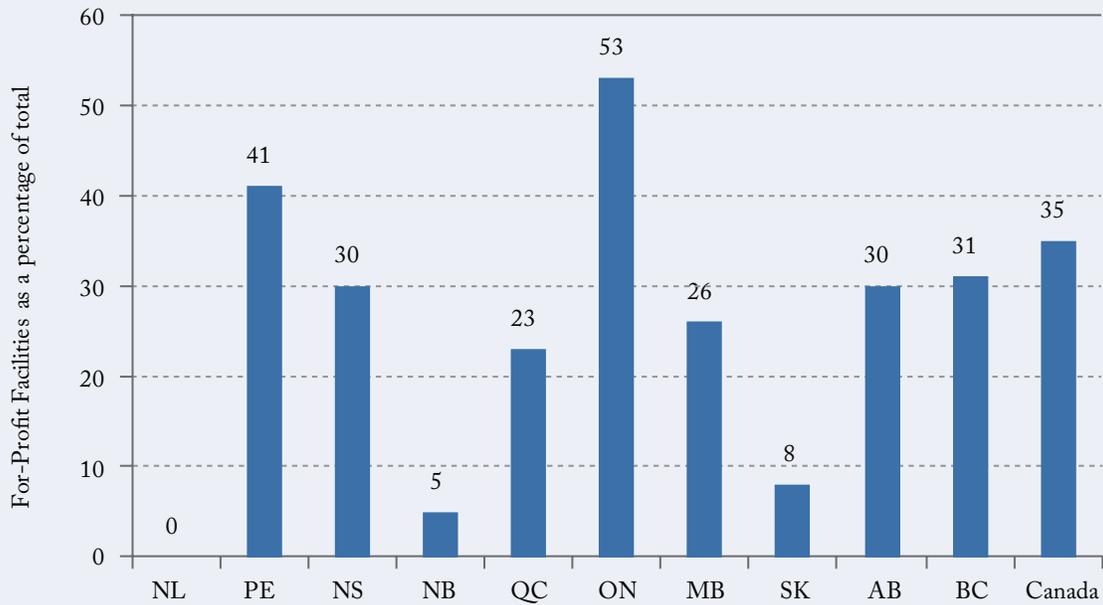
Given the limited resources available for publicly subsidized long-term care, informal providers supply most such services:¹⁴ In 2007, roughly one-fifth of Canadians age 45 and older, mainly family or friends, provided some unpaid long-term care to seniors (Statistics Canada 2008). To make the most efficient use of public resources, therefore,

formal services should go to those most in need of outside help.

In the existing systems, an individual's eligibility for different kinds of services is determined according to a single-entry system based on assessments by health professionals and the availability of providers.¹⁵ In general, admission to provincially subsidized support programs

- 14 Provincial programs do not give cash support to informal caregivers, but Ottawa and the provinces offer a range of tax benefits that provide at least some financial support and facilitate work-leave arrangements. Nova Scotia offers a large caregiver benefit, relative to other provinces, of up to \$400 per month to those who provide up to 20 hours of care per week for longer than 90 days.
- 15 Some provinces require applicants to be a resident of the province for a minimum period (see CHA 2009, table 5).

Figure 4: Publicly Funded For-Profit Nursing Home Beds, 2008



Source: CUPE (2009).

requires that the patient face complex ongoing care requirements, have limited informal home support, and cannot access affordable, alternative care. The provinces use a variety of assessment tools to determine need, but the general principle is that those with the highest need receive the highest level of support. Admission patterns in Ontario, which are probably similar to those in other provinces, show that 74 percent of new admissions from the community and 73 percent of admissions from hospitals are of patients with high or very high levels of need (Bronskill et al. 2011).

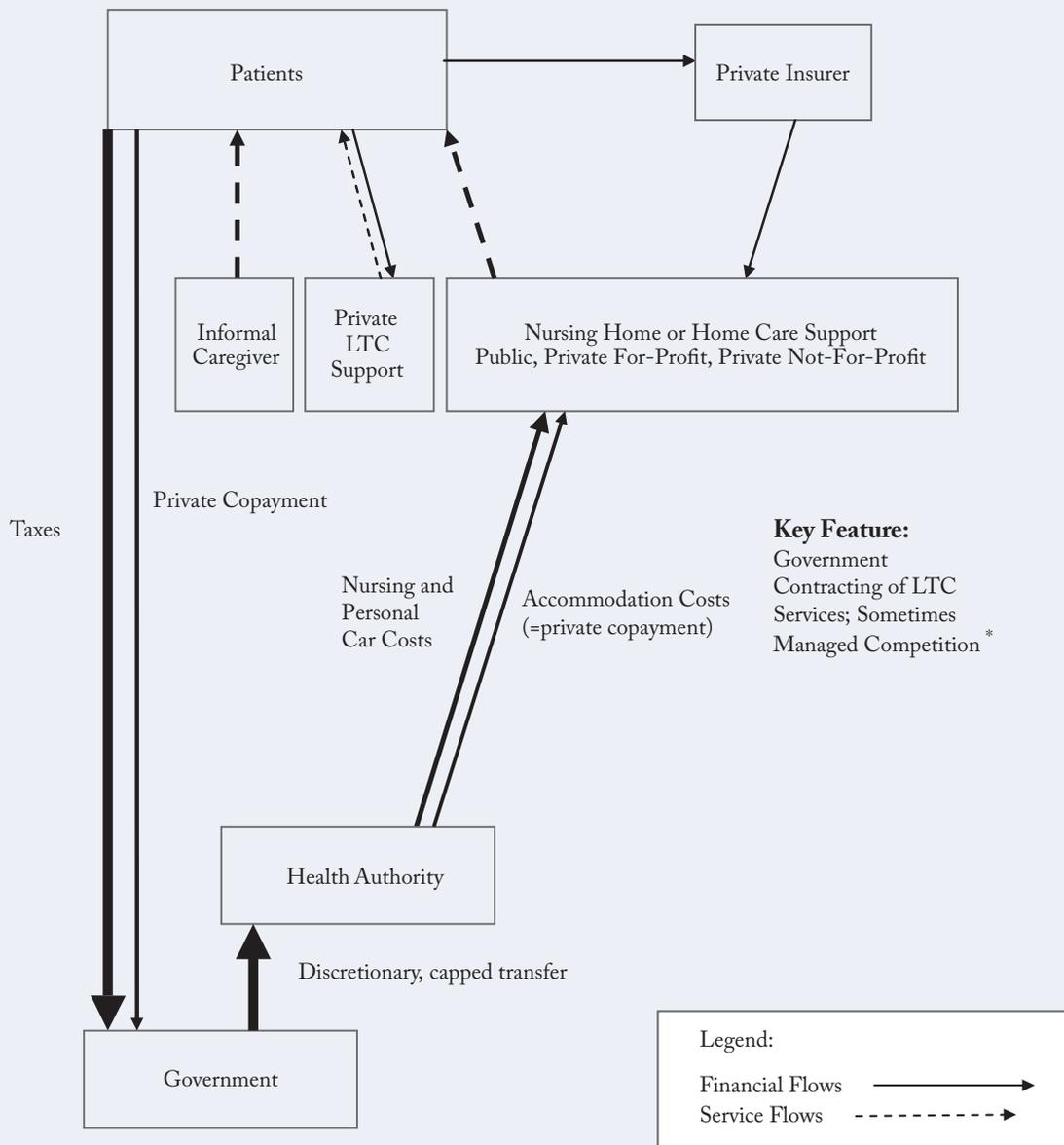
In Canada, all provinces use the same basic model of financing and in-kind services provision. Cast the net a little wider to include other advanced countries, however, and we see that many have developed quite different strategies to make LTC services affordable and to ensure that those they receive are providing the most value for money.

INTERNATIONAL EXAMPLES OF POLICIES TOWARD LONG-TERM CARE

International policy trends with respect to long-term care include public payments in the form of cash or vouchers to encourage greater competition among providers and more individual choice for patients. We highlight a few international examples that we think provide ideas to consider in the Canadian context.

The financing systems of the United States and the United Kingdom are at the safety-net end of the spectrum, where government funding is restricted to those who, in its absence, would not have the means to access urgently needed long-term care. At the other end of the spectrum are Japan and Germany, both of which come close to universality in offering the same level of subsidized long-term care to all citizens regardless of their income or assets.

Figure 5: Current Funding System for Long-Term Care in Canada



* At the time of writing, Alberta and, to some extent, Ontario are implementing a form of activity-based funding for long-term-care institutions, under which the facilities would be paid according to the needs of the patients under care.
 Source: Authors' compilation.

The US Backstop Example

The US system illustrates the advantages and disadvantages of a safety-net system, and suggests ways to mitigate its downsides. In the United

States, a large share of long-term care, especially that provided in institutions, is paid for by state Medicaid plans, which also offer acute-care health insurance to social assistance recipients and others who meet each state's low-income and asset criteria.

Medicaid’s acute-care health insurance is only for low-income individuals below age 65, whereas the federal Medicare program supplies universal health care coverage for everyone 65 or older. Like provincial health insurance plans in Canada, however, the federal Medicare does not cover long-term care, so state Medicaid plans – whose primary recipients are those on social assistance – include means-tested long-term care for individuals of all ages. Eligibility rules differ from state to state, but they typically include “spend-down” requirements specifying that individuals will not be eligible for a subsidy until they have few assets left, as well as low income.

Needless to say, these requirements are often controversial, and give rise to attempts by individuals to circumvent them, such as transferring ownership of assets to children before the need for long-term care arises – although changes in the means-testing rules have been designed to counteract such strategies (see Weiner, Illston, and Hanley 1994). Also controversial are cases where means-testing rules require a family home be sold before an elderly spouse’s long-term care is subsidized.

Public Coverage and Incentives to Purchase Insurance

The financial uncertainty that elderly individuals face because of the risk that they will need costly long-term care can be removed at least partially using private insurance, which is more common in the United States than in Canada, but still owned by only around 5 percent of all US seniors. In part, this is because the Medicaid safety-net insurance removes one of the main reasons for people to obtain private insurance in that it guarantees that people without enough income or assets will have access to long-term care. Moreover, under Medicaid’s spend-down provisions, subsidies to privately insured persons are reduced, dollar for dollar, by any benefits they receive from their private plans. In effect, people who buy private plans are paying for coverage to which they already are entitled, without payment, under Medicaid.

Some states have modified their Medicaid spend-down rules in a way that implicitly makes private insurance more attractive to individuals who are trying to protect some of their assets for the benefit of surviving family members: Under private-public insurance “partnerships,” the threshold values for the maximum amount of assets that individuals are allowed to keep are increased by the amount they have paid for their long-term care from benefits under their private plans. For example, a person whose private plan had paid \$100,000 toward the cost of his or her long-term care would be allowed to keep \$100,000 more in assets (perhaps to pass on to surviving family members) than a person without private insurance. Effectively, therefore, private partnership plans in the states allow individuals to use private LTC insurance to protect a portion of their assets for their families, without sacrificing their access to Medicaid LTC benefits.

A variety of policies have been suggested to make the US system more affordable for patients. They range from private sector initiatives, such as government-supported purchase of private insurance, to public sector initiatives that would see a much greater role for government in long-term care, to be paid for via social insurance schemes. Recently, the US federal government proposed a slight twist on the latter option with a voluntary social insurance plan (see Box 1).

Value for Money in Long-Term Care: International Models

A scan of OECD experience shows that reforms to improve value for money in the provision of long-term care have trended – notably in France, Germany, and the Nordic countries – toward cash- or voucher-based payments, rather than provision in kind. These new funding models are intended to be more reactive to patients’ needs, for example by enhancing the ability of people to stay in their homes rather than in institutions for as long as possible (see Box 2). Efforts to promote greater

use of formal and informal care in patients' homes have come from an expansion in overall home care budgets and a shift away from in-kind services towards cash benefits for home living (OECD 2011). Many countries' systems now include the option of making cash payments to patients to organize their own home care services, which also promotes competition among both home and facility-based providers.¹⁶

Financial and Service Flows

Financial and service flows for funding long-term care in France and the Nordic countries, in contrast to Canada, are intended to give patients a greater say over their path of care (see Figure 6). Instead of acting as the agent that pays for long-term care on behalf of recipients, government provides needs- and risk-adjusted transfers to patients with which they can purchase services from a variety of potential providers. Government in these countries still plays a critical role in regulating providers and ensuring they meet a minimum quality of care, but it no longer contracts with providers, who now engage patients directly. Further, informal care providers may be incorporated more formally into a patient's care plan as they are eligible to receive cash or voucher payments (provided they are not the patient's spouse).

The trend in many advanced countries toward the use of cash or voucher subsidies rather than services in kind was motivated in part by the belief that more choice for patients and competition among providers would lead to efficiency gains in the system and promote independence, if possible. The available evidence so far is inconclusive as to

whether these efficiency gains have materialized, but providing greater choice generally has increased the reported satisfaction of patients. Although many patients who were receiving cash or voucher transfers were not aware of the choices available to them and very few reported switching from one provider to another (OECD 2011), they nevertheless appear to have valued being involved in decisions about their long-term care, especially when also required to pay significant private costs.

RECOMMENDATIONS: FUTURE DIRECTIONS FOR LONG-TERM CARE IN CANADA

As Canada's population continues to age, long-term care for the frail elderly will require a growing share of society's resources. Provincial governments have strengthened their roles in the financing and regulation of long-term care in recent years, but they face tight financial constraints, and the debate over policy has not produced much of a consensus regarding future directions. Consequently, substantial differences remain in the degree to which government programs help to deal with the financial and other burdens many families face as a result of illness requiring long-term care, and in the methods they use to do so. In the next few paragraphs, we summarize our recommendations for the future directions we think the provinces should take with respect to subsidizing and regulating the long-term-care sector, keeping in mind both the fiscal pressures they face and the objective of offering high standards of public services and economic security to Canadians wherever they live.

16 Another interesting innovation is the approach of paying providers according to the health outcomes of the patients they care for. Many US states are experimenting with such pay-for-performance schemes, although developing the incentives and agreed ways to measure outcomes or care quality remain hurdles.

Box 1: An Optional Social Insurance Plan to Help with Future Costs of Long-Term Care

To encourage voluntary pooling of the risk of high costs of long-term care – and to reduce the tendency for individuals to overlook such risk – one of the Obama administration’s health insurance initiative, the *Community Living Assistance and Services (CLASS) Act*, originally included provisions for a government-managed but voluntary insurance scheme.* The plan would have offered long-term-care insurance to working individuals, typically as part of employers’ benefit packages, and would have been available to everyone on the same terms, regardless of previous illness history, with benefits in the form of cash payments that could have been used either for home care or towards the cost of institutional care.

As a voluntary plan, it would have been possible for those offered it through their employers to opt out. It also would have offered cash benefits, rather than services in kind, so as not to steer recipients toward one form of care or another. The plan was intended as a complement to Medicaid, but it did not address directly the lack of incentive for individuals to obtain voluntary coverage when part of it was available for free through Medicaid. In the face of uncertainty about how large enrollment would be and the plan’s financial viability without government support, the administration withdrew the plan in 2011.

* For more detailed explanations of this policy, see OECD (2011, 287).

Financing Long-Term Care: Universality or Targeted Subsidies?

In the universal acute-care model under the *Canada Health Act*, provincial governments must take responsibility for covering the full cost of all physician and acute-care hospital services that any patient uses. Universality has the advantage of administrative simplicity, and many will argue that it is the right approach for long-term care as well, in that it spreads the burden among all taxpayers (see Grignon and Bernier 2012). At the same time, it is a very costly principle to government if it means that everyone, regardless of ability to pay, receives the same level of subsidy or qualifies for assistance with home care. In an environment where tax rates are projected to rise because of demographic

and growth pressures on the current system, the cost to the economy from raising additional tax revenue will be high. Moreover, considerations of intergenerational equity – and the smoothing of tax rates across different age groups – provide an additional powerful argument in favour of limiting government subsidies to those who need them the most.

We believe that targeting subsidies according to ability to pay is the right choice in this context, and can be done whether benefits are provided in kind or in cash. The current provincial systems provide benefits in kind, and accomplish targeting through patient co-payments that are differentiated according to ability to pay, as measured either by patients’ (and sometimes, their families’) income or income and assets combined.¹⁷

17 If subsidies were paid in cash, targeting would be accomplished simply by reducing the amount of benefit according to the patient’s ability to pay, as France does, for example.

Box 2: Paying Providers: International Models

The trend in government financing models of long-term care is generally toward subsidizing services with direct cash or voucher transfers, as is done in France, Germany, and some Nordic countries.*

The French Example: Cash Payments Based on Needs and Income

In 2002, France introduced an allocation personnalisée d'autonomie (APA, personal autonomy allowance) for individuals needing help with activities of daily life and limited independence. APA is universally available for those ages 60 and older who have long-term-care needs and live either at home or in an institution. For home-care needs, APA provides support for services deemed necessary by case evaluators, which includes financial support for caregivers, excluding a spouse or partner. For those in facility-based care, the APA pays for a portion of the costs; the resident pays the remainder either out of pocket or through private insurance. The size of the allowance increases with the patients' assessed level of dependence and decreases with rising income. Maximum monthly benefits are roughly €1,300, or \$1,600.

The German Example: The Choice between In-Kind or Cash Benefits

In Germany, once qualifying for public coverage of long-term care, a beneficiary must decide, every six months, between receiving benefits in kind, in cash, or as a combination of both. Allowing patients to choose between in-kind care and a cash payment stems from concerns that individuals might misuse cash benefits; hence, the level of cash payments is set lower than the costs of providing in-kind services, which nudges patients toward in-kind care. Since this plan was introduced, more individuals have chosen to receive their care in kind rather than in cash. Subject to co-payments, cash and in-kind benefits are offered according to need, with three levels of care, and the same level of benefits regardless of income. Formal in-kind care providers are almost entirely private for-profit and not-for-profit, and are offered contracts that are reviewed annually.

The Nordic Countries' Example: Vouchers for Services

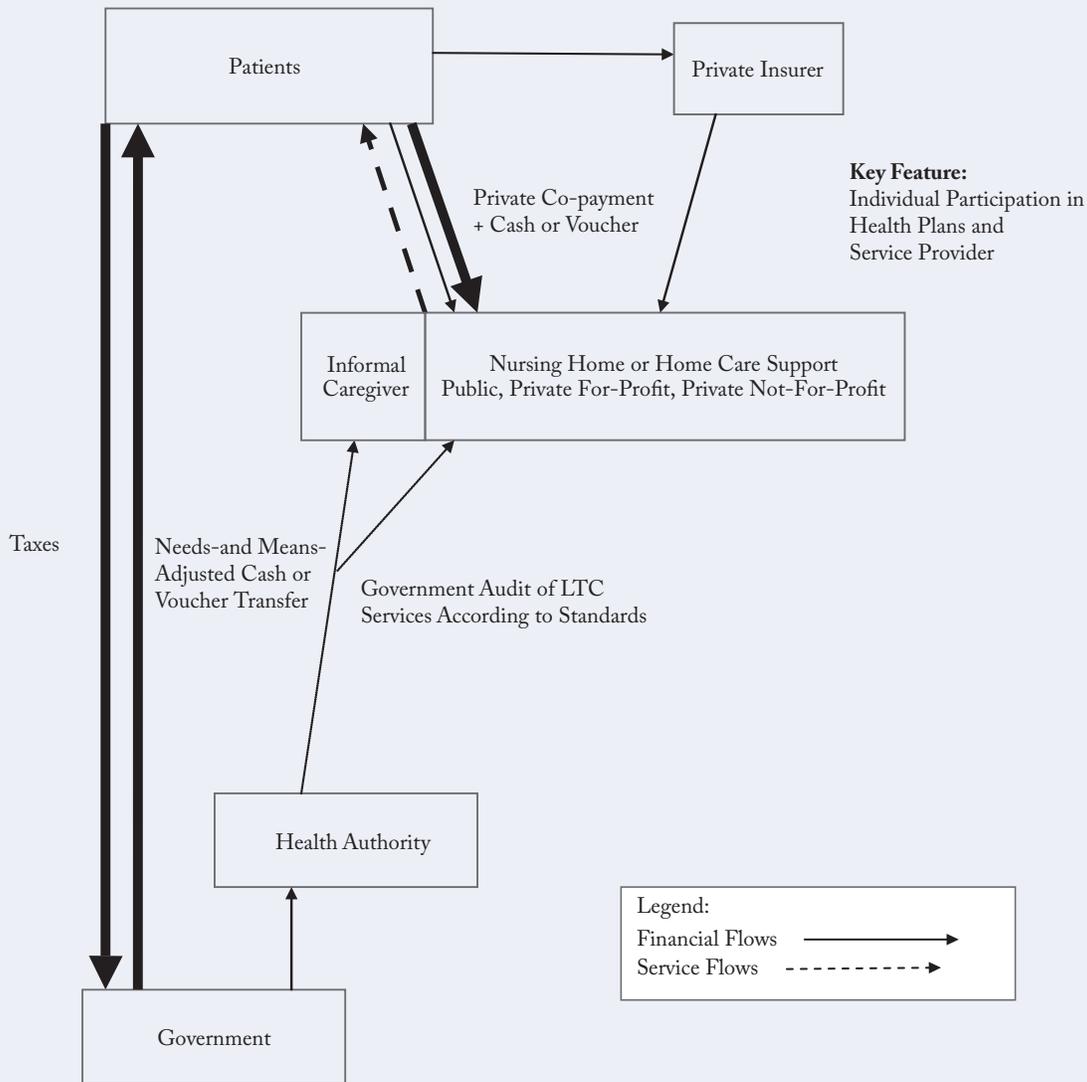
In Sweden, Finland, and Denmark patients in long-term care receive vouchers with which they may choose among providers of a restricted set of services, either in home care or in institutional care. In Finland, the size of the voucher depends on household composition and income, and patients pay the difference between the size of the voucher and the cost of services; as well, vouchers cannot discriminate between providers. In Denmark, however, each provider must meet minimum standards to qualify among a potential group of eligible caregivers. Supplementary payments from patients generally go directly to the service provider rather than to the government.

* For more detailed explanations of these national plans, see OECD (2011).

Targeting according to ability to pay does have adverse incentive effects, however: The dollar-for-dollar reduction in public benefits decreases the expected return of working Canadians to save for

old age, and encourages those with growing long-term care needs to deplete their income-yielding assets faster than they would if they were allowed to keep a larger share of their income or assets.

Figure 6: Funding System for Long-Term Care in France and Some Nordic Countries



Source: Authors' compilation.

But these effects are delayed and are unlikely to be as significant as those of raising tax rates for the working-age population. To us, this difference creates the strongest argument in favour of a targeting approach, along lines similar to those of the current OAS/GIS model of retirement income security, as opposed to a model with universal and equal benefits.

How to Target Public Support for Long-Term Care

With a targeted approach to public support for long-term care, two issues are critical. First, how should patients' ability to pay be measured? Second, at what rate should subsidies be clawed back as the measure of the patient's ability to pay increases?

In defining ability to pay, the choice between a model based on income alone, or on both income

and assets, becomes critical, as does the issue of how the patient's family is to be treated in the targeting. As noted above, most provinces focus on income, partly to protect the assets of elderly spouses who remain in the community. While we recognize the legitimacy of this objective, we nevertheless believe that targeting based on both assets and income would be a better model. For a retired person, unlike a younger individual of working age, the distinction between expected future income and current assets is not very relevant in measuring his or her ability to pay. For this reason, we recommend a model under which a family's annual ability to pay includes a percentage of its total assets, with the percentage depending on the patient's age, as well as any income from other sources. Given the likelihood that patients would seek to avoid strict asset tests, as seen in the US, asset thresholds should likely only include a fraction of one's total wealth.

Financial protection for elderly spouses of patients in long-term care could be accomplished in a number of ways. One approach would be to defer collection of payments until the death of the patient or any surviving spouse. An example of this approach – found in many US states – is that of reverse mortgages or deferred payments against home equity. Under these payment mechanisms, patients do not have to pay their share of the cost in cash immediately; instead, the provider (typically a nursing home) acquires a mortgage on the home and is paid when the mortgage falls due, which may be when the house is sold or on the death of the surviving spouse. In Canada, where subsidized long-term care is supplied in kind and nursing homes are paid by the provinces, it would, of course, be the provincial government, not the provider, that would acquire the mortgage, but the principle is the same.

With respect to the clawback rate of public support, in most provinces, elderly individuals, or families with an income no higher than that defined by OAS/GIS, are fully subsidized and pay the minimum “facility fee” co-payment. For those with an income above the threshold, the annual co-payment rises by one dollar for each additional dollar of income, however measured, up to a specified maximum. That is, the implicit clawback rate in the interval between the minimum and the maximum co-payment is 100 percent. Provinces differ widely, however, in terms of the maximum co-payment, and not all of them have a 100 percent clawback rate – in Saskatchewan, for example, the implicit rate is roughly 50 percent, as noted earlier.

The principle that seniors with no assets or income beyond OAS/GIS should be fully subsidized seems reasonable. Then, the subsidy cost to government would depend on the clawback rate, the level of the maximum co-payment – that is, the minimum subsidy – and the income measure used to define patients' ability to pay. On balance, we support a model with a comprehensive definition of income. Such a model would include a high maximum co-payment – making high-income patients responsible for the full cost of their long-term care, excluding the cost of the drug or physician services they receive – but with a clawback rate lower than 100 percent. This would recognize the incentives against honest income and asset reporting, and against savings, that high clawback rates imply.¹⁸

Targeted Subsidies and Voluntary Insurance

A guarantee of access to long-term care for those who lack the means to pay for it on their own removes much of the incentive for individuals to

18 Note again that these recommendations would result in a system similar in some respects to the current OAS/GIS for retirement income support. In that system, different clawback rates apply to people receiving GIS and to those who receive only OAS. As in the case of OAS, the long-term-care subsidy could disappear entirely above some income level.

acquire private insurance that covers the cost of such care, at least for elderly persons who will be in care until they die. Among the elderly, then, the demand for private insurance essentially would be limited to those who want to pass on assets to their heirs.

If government subsidies are based on the model of targeted universality, one important determinant of the demand for private insurance would then be whether or not individuals' eligibility for subsidies depends on their assets. If it does not, the demand for private insurance would be reduced since the subsidies would allow them to pay for their long-term care without drawing on their assets. For this reason, the demand for private insurance could be expected to increase if more provinces move in the direction of comprehensive definitions of ability to pay that include a percentage of patients' assets.

In a system of targeted subsidies, private insurance would reduce the future expected subsidy costs government would incur in a given population, to the extent that the benefits insured persons received reduce the subsidies to which they were entitled under the government program. For this reason, a case can be made for some degree of subsidy or tax credit for private individuals who sign up for such insurance (CLHIA 2012). But it would not be easy to establish how large such a subsidy should be, as the answer will be influenced by factors such as the extent to which the demand for insurance responds to its premium cost and on the state of competition in the market for insurance.¹⁹

One approach would be to direct government subsidies for long-term care to a compulsory earmarked social insurance plan. Compulsory social

insurance contributions have essentially the same negative incentive effects as taxes, so this solution would be open to the same objections as increased government subsidies in general. A *voluntary*, government-sponsored social insurance plan that pays out benefits in cash or vouchers, however, is more appealing. To encourage greater use of long-term care insurance and prefunding in financing long-term care – and to nudge people to save more for their retirement – an optional government plan, similar to the US Community Living Assistance and Services proposal (see Box 1), merits consideration.

An additional issue when targeting subsidies is public confusion about the extent of their government supports, which might lead people to overestimate the public share and underestimate how much they need to save privately, assuming that government will bail them out if needed. Once the public share is set, a key priority for government, therefore, is to ensure that citizens understand the private burden of care costs, and to emphasize the need to plan for them.

Value for Money: Subsidies in Cash or in Kind?

Competition can act as an incentive for producers to be efficient and to offer higher-quality services. On the buyers' side of the market, patients who do not receive a subsidy pay for services directly, with fees and charges established through normal market processes. Canadian patients, however, mostly receive services in kind, so that even though they usually pay part of the cost, the terms of supplied services are negotiated between the province, as purchaser, and the providers. In these markets,

19 Estimates from the United States suggest that the demand for long-term-care insurance is not very responsive to premium costs, even for employed young individuals whose premiums would be considerably lower than those of their older counterparts (Weiner, Illston, and Hanley 1994). Nevertheless, offering a subsidy or tax credit for private insurance could be beneficial in nudging individuals toward paying more attention to accumulating resources for their old age, especially if they want to leave something for their children.

therefore, providers do not compete directly for patients – although, in some provinces, providers compete for contracts with the government to produce the in-kind services that subsidized patients receive.

We believe provinces should consider placing more emphasis on paying cash or giving voucher subsidies directly to patients, rather than providing services in kind.²⁰ For most recipients, such a shift would not make a difference, since they would buy the same services with a cash subsidy that they currently receive in kind. But for some the extra flexibility would give them a chance to make choices, including applying the voucher towards home care services, as well as incorporating informal caregivers into their care packages. In markets where consumers have more flexibility in choosing providers and patterns of care to suit their circumstances and preferences, competing providers have more opportunities to offer specialized or innovative services. As the experiences of Germany, France, and the Nordic countries show, cash and voucher subsidies could be helpful in creating innovative variations on the basic model of long-term care and in improving overall satisfaction with the system.

In the nursing home market, a side benefit of offering patients a cash subsidy as an alternative to benefits in kind might be to reduce the length of waiting lists. Some patients might take the cash subsidies and pay additional money out of pocket to receive more home care than they would be entitled to under the in-kind option. Others might choose to use the cash subsidy to enter a higher-priced private facility in order to bypass the waiting list. Indeed, this outcome could be encouraged by government policy to arrange for the supply of provincially funded medical and other services (such as case

management) to private nursing homes that admit both subsidized and unsubsidized patients.

Risks and Challenges in a Voucher System for Long-Term Care

Subsidization of long-term care through cash or vouchers does, of course, have possible drawbacks. One concern is that providers will seek out patients with low-care needs relative to costs – the cream-skimming problem familiar from private health insurance. Another concern is the increased difficulty of governments to exercise a high level of control over their annual health budgets. One might also fear that under a voucher system, providers would increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. To counteract these problems and control costs, the government could – like in the German system – offer a sliding scale of vouchers based on the recommended level of care. For instance, if a patient chooses the care path recommended by health professionals, he or she would receive in-kind services of a predetermined value. But, if this individual were to choose an alternative care path, he or she would be eligible to receive a voucher worth less than the cost of providing in-kind support; hence nudging the patient towards the prescribed care path.

Some also might argue that the increased use of untrained informal caregivers would place the quality of care at risk, and elderly individuals might not be well informed about their best options for care. These problems could be mitigated by having qualified medical personnel work with patients in formulating appropriate care paths, and by connecting informal caregivers with subsidized

20 At the time of writing, the Toronto Central Community Care Access Centre is experimenting with a pilot program that incorporates vouchers.

training programs.²¹ The provinces would still set and enforce regulations and minimum standards for care.

One additional potential weakness of a voucher system – one shared with the current system of long-term care found in most provinces – is that the size of the voucher, or public subsidy, needs to change over time with a patient's needs. The number of chronic conditions suffered by individuals in long-term care tends to grow over time – after a patient has been admitted to a residential care facility his or her needs might increase dramatically. Without regular adjustments to the level of subsidies, long-term-care facilities might have to discharge more patients to hospitals if care needs become too burdensome. A well-designed voucher program should take into account the scale of long-term-care needs and periodically revise the size of the voucher accordingly.

Governments could transition to a voucher-type model in two easy steps. First, in assessing patients for long-term-care needs, administrators should consider only their activities of daily living and limitations (their need for care), not the availability of family support. Second, patients eligible for nursing home placement or home care should be able to choose either to be put on the waiting list for home or facility-based care or receive a subsidy (as in Germany) they can use in the private market. At the same time, the system under which governments certify the quality of care offered in private homes could be strengthened to ensure that those who choose the subsidy receive competent private care.

The Efficient Use of Long-Term and other Healthcare Resources

The strengthening of community-based care is a welcome element of long-term-care policy in many provinces.²² Getting the balance right between community-based and institutional care is important from the viewpoint of the cost to governments, as increased home care resources could delay the transfer of patients to more expensive institutional care. It also could help make more efficient use of acute-care hospital capacity to the extent that it allows patients to be discharged into the community sooner. Increased access to home care also likely would be more efficient from the viewpoint of social costs, as it would reduce the heavy burden of many family caregivers.²³

An important aspect of this issue relates to the impact of the choice, as between institutional and home care, on the cost of delivering needed acute-care services to different categories of patients. The interaction between the cost of acute care and long-term care is relevant in evaluating both the total social cost of caring for patients and the benefits of increasing home care resources while saving acute-care hospital costs. Many countries, including Germany and Belgium, are tackling this problem, in part, by charging patients the same accommodation charges in acute-care hospitals as they would have to pay in a long-term-care facility as a way to encourage shorter hospital stays. In Canada, such charges have been resisted on the grounds that they are contrary to the CHA rule against user charges. We do not believe, however, that this rule should

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- 21 For example, in the same way that Community Care Case Managers/Coordinators in Ontario help assess patient risks and identify care priorities for patients in today's system, these responsibilities could be extended to patients under a voucher-type program, where the default care plan for the patient is the one recommended by the case manager.
- 22 There exist many practical recommendations to reform the long-term-care sector to achieve a better performing health system. Walker (2011) and Dillane and Reichman (2012), although focusing primarily on Ontario, cover a suite of sensible options and go into much more detail than space permits here.
- 23 As the trend toward more community care is now well established, however, it might be time ask how far it should go. Further research on the relative cost of caring for individuals with different degrees of disability in institutional versus community settings could help fine tune this aspect of policy toward long-term care.

apply to ALC patients who remain in acute-care beds when places in nursing homes or sufficient home care services are available for them but the patient chooses to decline these options, for example. A ruling from the federal government, on CHA compliance, to this effect could help address this long-standing issue.

Although the design of a menu of long-term-care services that promotes efficient use of resources in the healthcare sector is important, ensuring that the various programs are managed efficiently is even more so. In a number of provinces, a critical shortcoming of the current system of financing and regulating long-term care is the existence of waiting lists for both institutional care and certain types of home care. The inefficiencies that are likely to arise from rationing-by-waiting-list are well known from basic economics, and they do arise in the long-term-care context, resulting in pressure and costs elsewhere in the health system. Reducing waiting lists thus should be a high priority. In the short run, it might even be worthwhile to allow patients' charges to rise until the waiting lists disappear, although the best strategy in the long run would be to expand the supply of services for which waiting lists currently exist.

CONCLUSION

Long-term care is certain to become a rapidly growing component of provincial healthcare expenditures in the years to come. As Canada's society ages, more personal care and health support will be needed for people who, either as a consequence of disability or aging, require assistance to function independently. As this happens, policymakers, in the face of existing fiscal burdens and the increased demands that lie ahead, must balance caring for individuals with long-term needs and the burden on future taxpayers. This is a thorny challenge. But policymakers should tackle these tough issues now, before the first wave of baby boomers begins to draw heavily on long-term care programs in about 15 years' time.

Policy reforms will require methods to contain costs, to fairly divide these costs between care recipients and taxpayers, and to get more value for money in a sector that will feature prominently in future economic policy debate. There is no obligation under the *Canada Health Act* for the provinces to provide universal long-term care without private charges; instead, provincial governments will decide on such issues as the level of public support versus private charges, eligibility criteria, and standards of quality for long-term-care delivery. Diversity in provincial approaches is healthy, and more comparative analysis of the experience in different provinces, as well as in other countries, would be helpful in developing future policy.

While the provinces clearly have to subsidize long-term care for those who lack the means to pay for it, we favour a targeted approach, under which public subsidies diminish with individuals' ability to pay – defined so as to reflect both income and assets. In designing the targeting rules, provinces should find ways to treat assets flexibly for elderly couples when one spouse has high long-term-care needs and the other spouse remains in the community. Further, so as not to unduly discriminate against middle-income seniors with accumulated savings, the provinces could establish a more gradual scale to reduce the size of public subsidies, one that does not reduce the subsidies by one dollar for each additional dollar of private income or assets. Private insurance to help pay for long-term-care costs could be encouraged, especially for seniors who wish to pass on assets to their heirs, and might reduce the need for public subsidies to a limited extent.

Perhaps most important, governments must aim to get good value for the money they spend on long-term care, and on this score there are many opportunities to improve efficiency in the sector – some European countries seem to be far ahead of Canadian provinces in doing so. Reforms should insist on measures that eliminate the waiting lists that currently exist for many services and improve



the location of care around patients' preferences. We believe the provinces are more likely to accomplish these goals if they channel more subsidies for long-term care directly to patients – in the form of

vouchers or cash – rather than paying the suppliers of services, and if they allow patients a greater role in choosing among competing suppliers.

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