The Cost of Care: A New Framework for Financing Long-term Care in Canada

by

Silver McLaughlin

B.A., Queen's University, 2019

Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Policy

in the
School of Public Policy
Faculty of Arts and Social Sciences

SIMON FRASER UNIVERSITY
Spring 2021

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Name:	**Silver McLaughlin**
Degree:	**Master of Public Policy**
Thesis title:	**The Cost of Care: A New Framework for Financing Long-term Care in Canada**
Committee:	**Chair:** Dominique Gross Professor, Public Policy
	John Richards Supervisor Professor, Public Policy
	Nancy Olewiler Examiner Professor, Public Policy

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Abstract

As the Canadian population ages, the demand for adequate long-term care (LTC) increases and with it, higher long-term care costs. The distribution of increased costs between Canadian seniors, their families, and Canadian governments is an important issue to resolve. This study examines existing LTC policies in order to systematically identify areas for reform, then develops and assesses policy options to guarantee that adequate LTC will be available, at a reasonable cost and appropriate efficacy, to every Canadian who requires it.

Keywords: Long-term care; Canada; cost distribution; horizontal equity; intergenerational equity

Acknowledgements

I would like to acknowledge the many people who have supported me throughout this research. First, thank you to my supervisor, John Richards, for your guidance, encouragement, and enthusiasm while undergoing this project. Second, thank you to my external examiner, Nancy Olewiler, for her thoughtful feedback and insights for the completion of this Capstone.

I would like to thank the interview participants who provided the expertise and feedback needed to accomplish the goals of this study.

Finally, thank you to my friends and family for your endless support and throughout this degree.

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List of Acronyms

APA	Allocation Personnalisée d'autonomie
CIHI	Canadian Institute for Health Information
CHA	Canada Health Act
CHT	Canada Health Transfer
CLHIA	Canadian Life and Health Insurance Association
GIS	Guaranteed Income Supplement
GDP	Gross Domestic Product
LTC	Long-term care
LTCI	Long-term care Insurance
NIA	National Institute of Aging
OAS	Old Age Security
OECD	Organization of Economic Cooperation and Development
WHO	World Health Organization

Glossary

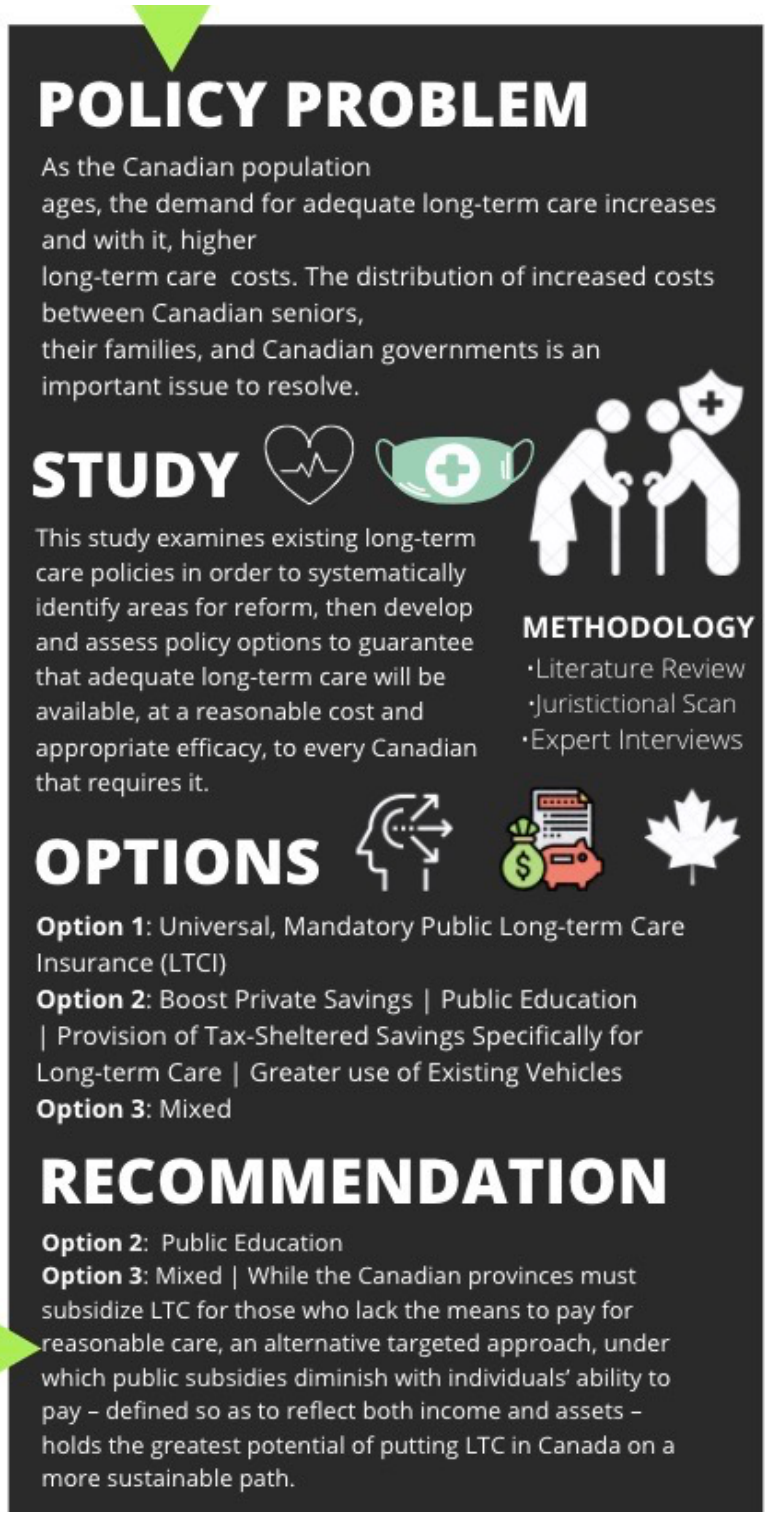
Activities of Daily Living	Basic tasks that must be accomplished every day for an individual to thrive. Generally, these activities can be broken down into the following categories: personal hygiene, continence management (person's mental and physical ability to properly use the bathroom), dressing, and feeding.
Alternate Level of Care	Is used to describe persons who occupy a bed in a facility but no longer require the intensity of resources and services provided in that setting (CIHI, 2017).
Baby Boomer	Refers to a member of the demographically large generation born between the end of WWII and the mid-1960s.
Canada Health Act	A piece of Government of Canada legislation, adopted in 1984, which specifies the conditions and criteria with which the provincial and territorial health insurance programs must conform in order to receive federal transfer payments under the Canada Health Transfer. The aim of the CHA is to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such services.
Co-payment	A co-payment or co-pay is a fixed amount for a covered service, paid by a patient to the provider of service before receiving the service.
Designated Building	The types of LTC that are provided in a designated building designed or organized to facilitate the provision of LTC in congregate settings (including nursing homes, retirement homes, residential facilities, assisted living facilities, supportive housing building models) as opposed to a private residence or community-based setting.
Formal Care	Paid care services provided by a healthcare institution or individual for a person in need.

Home and Community Care	Care that is provided in home-based settings rather than in a hospital, nursing home or LTC facility, which allows individuals to remain independent in the community. This type of care can be provided by regulated healthcare providers (i.e. nurses, therapists), but also by non-regulated care providers such as personal support workers (PSWs) also known as health, continuing or simply 'care aides' (H-/C-/CAs) or nursing aides, volunteers, and unpaid caregivers (i.e. friends, family, and neighbours) (Government of Canada, 2016). The Canadian Home Care Association (CHCA) (2016a) has promoted a more encompassing definition of 'Home and Community Care' as an array of both health and support services provided in the home, retirement communities, group homes, or other settings to people with acute, chronic, palliative, or rehabilitative healthcare needs. These services consist of assessments, therapeutic interventions, personal assistance and unpaid caregiver respite and support (CHCA, 2016a). Overall, this type of care is recognized as an 'extended health service' and is thus not designated as an insured service under the CHA (CHCA, 2013). This has resulted in each province and territory developing their own legislation and accompanying policies and regulations to govern the provision of home and community care.
Informal Care	Unpaid care provided by family, close relatives, friends, and neighbors.
In-kind	Paid or given in goods, commodities, or services instead of money.
Instrumental Activities of Daily Living	Are somewhat more complex than activities of daily living, but nevertheless also reflect on a person's ability to live independently and thrive. These activities include: securing assistance for companionship and mental support, transportation and shopping, preparing meals, managing a person's household, managing medications, communicating with others, and managing finances.

Long-term care	National Institute on Aging (NIA): A range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living and Instrumental Activities of Daily Living provided by either not-for-profit and for-pro fit providers, or unpaid caregivers in settings that are not location specific and thus include designated buildings, or in home and community-based settings. World Health Organization (WHO): The activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity. Organization for Economic Co-operation and Development (OECD): A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living. This “personal care” component is frequently provided in combination with help with basic medical services such as “nursing care” (help with wound dressing, pain management, medication, health monitoring), as well as prevention, rehabilitation or services of palliative care. LTC services can also be combined with lower-level care related to “domestic help” or help with instrumental activities of daily living.
Long-term Facilities-based Care | Institutional LTC	In general, LTC facilities and/or institutions provide living accommodation for people who require on-site delivery of supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping. Long-term facilities-based care is not publicly insured under the Canada Health Act. It is governed by provincial legislation. Across the country, jurisdictions offer a different range of services and cost coverage. Consequently, there is little consistency across Canada in: what facilities are called (e.g. nursing home, personal care facility, residential continuing care facility, etc.); the level or type of care offered and how it is measured; and how facilities are governed or who owns them.

Means-test	An official investigation into someone's financial circumstances to determine whether they are eligible for a welfare payment or other public funds. In most provinces, LTC co-payment amounts are adjusted according to the means-test/ the monthly rate is calculated based on an individual's "after tax income".
OAS & GIS	The Old Age Security program is a universal retirement pension available to most residents and citizens of Canada who have reached their 65th birthday. This pension is supplemented by the Guaranteed Income Supplement for seniors with lower incomes, which is added to their monthly OAS payment.
Patient, Client, Resident, Recipient	All apply to those seeking or receiving LTC.
Supportive Housing, Assisted Living, or Retirement Homes	Describe a different type of living arrangement in a specific location. The defining feature of this type of housing is that the support services are included in a care package delivered in a designated building. These services vary but can include meals, assistance with bathing, or access to an on-call nurse and/or non-regulated care provider. These types of housing options can be owned and operated privately, while others are owned and operated by not-for-profit organizations. Some are government-owned and operated by local municipalities. As is also the case with 'Home and Community Care,' this province directed approach has led to a considerable lack of consistency across the country in the level or types of care that are being offered, how care can be accessed, funded and measured, and how providers are governed, operated, and staffed (Government of Canada, 2010).

Executive Summary



Chapter 1. Introduction

Long-term care (LTC) consists of a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living and Instrumental Activities of Daily Living provided by either not-for-profit or for-profit providers, or unpaid caregivers in settings that are not location specific and thus include designated buildings (including nursing homes, retirement homes, assisted living facilities), or in-home and community-based settings (Sinha et al., 2019). Most seniors will typically require some form of LTC as they enter into their later years (Grignon & Bernier, 2012).

LTC has never been a priority for Canadian Medicare. Medicare was established in 1965, a time when most senior Canadians were cared for by relatives in the family home, and rarely lived long enough to need the high levels of complex care that would require institutionalization (Hirdes, 2008). Even as the need for more complex care grew in the decades that followed, LTC was never enshrined in the Canada Health Act (CHA). Therefore, LTC for seniors often falls outside the scope of the public healthcare system, which primarily covers hospital and physician services. LTC is delivered by the Canadian provinces through a mixture of publicly-funded programs, which seniors can supplement with privately-paid services, and care provided by unpaid caregivers. The eligibility criteria attached to LTC available through the public system, the scope of care and cost to individuals differ dramatically among Canadian provinces (Worsfold et al., 2018). As a result, access, as well as the financing of LTC in Canada is a patchwork.

Many Canadians are unaware of the likely cost burden of LTC expenditures. A 2015 Leger Marketing Survey conducted for the Canadian Life and Health Insurance Association (CLHIA) found that 55% of Canadians believed that government programs would cover half or more of the cost of their LTC needs (Adams & Vanin, 2016). On the 2013 Sun Life Canadians Health Index Survey, almost one in two (47%) indicated that they would not expect to pay out-of-pocket for a retirement home residence and six out of 10 indicated that they would not expect to pay out-of-pocket for a nursing home (Ibid). Typical annual costs to individuals requiring the use of LTC services can range from $25,000 to $200,000 per year, depending on the service type and means-testing (*The*

Cost, 2018). The high costs of LTC threaten the financial stability of Canada's aging population. While some Canadians are able to absorb the impact, many are not factoring in the high costs of LTC when planning for retirement (Ibid).

As Canadian lifespans lengthen and given the high fertility rate in the two decades following WWII, an increasing number of Canadians will require LTC (Blomqvist & Busby, 2014). Projections indicate that the Canadian working-age population, which pays the dominant share of taxes required to finance LTC, as well as other programs that transfer income to seniors in Canada, will decline as the "baby boom" cohorts enter the frail (post-75) elderly stage of life (Ibid). The pressures on future workers to finance LTC can be estimated by the dependency ratio (the senior population ages 65 and over plus the under-15 cohort relative to those in the active workforce ages 15-64) which is rising across Canada (Blomqvist & Busby, 2012). As a result, immense stress will be placed on the future budgets of individuals and governments. This has led many to question the sustainability of present Canadian LTC financing. These concerns have been magnified in the context of the unprecedented COVID-19 pandemic, as over 80 percent of COVID-19 deaths in Canada have occurred within LTC facilities (Colleta, 2020). The pandemic has served as a focusing event that has directed public attention towards the sustainability of LTC in Canada.

This brings us to the problem that this study addresses: **As the Canadian population ages, the demand for adequate long-term care increases and with it, higher long-term costs. The distribution of increased costs between Canadian seniors, their families, and Canadian governments is an important issue to resolve.** Will Canadian governments pay for these costs out of general budgets or will they leave all or a portion of the financial burden to those needing care and their families? In other words, what are the right shares of public and private coverage in LTC? Canadian policymakers face the challenge of balancing the fiscal burden on taxpayers with the need to ensure that all individuals with LTC needs receive proper care (Blomqvist & Busby, 2012).

This study examines existing LTC care policies in order to systematically identify areas for reform, then develop and assess policy options to guarantee that adequate LTC will be available, at a reasonable cost and appropriate efficacy, to every Canadian who requires it.

The chapters that follow aim to address the key questions that have been outlined above through various methods, with the overall goal of providing viable and adequate options to begin to resolve the issue at hand. First, Chapter 2 explains the methodologies used: a literature review, jurisdictional scan and expert interviews. Chapter 3 outlines Canadian demographic projections that are relevant to LTC demand. The next chapter contains an extensive overview of studies that have developed future LTC cost estimates (Chapter 4). Chapter 5 provides a summary of the current Canadian LTC financing approach. Chapter 6 contains the key findings from the jurisdictional scan. The following chapter presents the criteria and measures that are used to evaluate the benefits and drawbacks of proposed policy options. A total of three policy options are presented and described in detail (Chapter 7). Chapter 8 analyzes each policy option using the criteria and measures outlined in Chapter 7. Finally, recommendations are made based on this analysis (Chapter 8).

Chapter 2. Methodology

2.1. Primary Methodology: Literature Review | Jurisdictional Scan

Data collected from the literature review and scan of LTC policies in other jurisdictions has been used to gain a well-rounded understanding into the various policy areas and effectiveness of specific policies aimed at meeting the increasing demand for LTC.

An extensive review of population projections on government websites, studies that have developed cost estimates, as well as existing academic literature on policies within Canada and other OECD countries have been used to inform the policy review.

2.2. Secondary Methodology | Expert Interviews

Throughout November 2020, five in-depth semi-structured phone interviews were conducted with experts including academics and policy analysts involved in researching LTC policies in Canada. The main priority of interview recruitment was to ensure that individuals with different roles within the field of LTC and divergent views on LTC policy were included. Table 1 lists the interviewees and their academic and/or professional experience relevant to this study.

Table 1. Expert Interviews

Interviewee	Areas of Expertise
Mohsen Javdani, PhD Associate professor of economics in the School of Public Policy and Urban Studies at Simon Fraser University. Prior to joining SFU in 2020, he was a faculty member in the Department of Economics, Philosophy, and Political Science at the University of British Columbia (Okanagan Campus).	• Economics of gender; • Economics of immigration and minorities; • Economics of education; • Personnel economics; • Role of ideological bias in economics; • Studying and challenging mechanisms and processes that hinder plurality and produce inequality, injustice, exclusion, and marginalization.
Åke Blomqvist, PhD Adjunct Research Professor, Carleton University and Health Policy Scholar at the C.D. Howe Institute.	• Methods of health care financing; • LTC • Comparative health policy; • Health care reform in China; • Economics of developing countries.
Colin Busby, MA Research director at the Institute for Research on Public Policy (IRPP). Before joining the IRPP, he was the associate director of research at the C.D. Howe Institute. He has also worked at Industry Canada and the United Nations Industrial Development Organization.	• Fiscal policy; • Social policy; • Health policy; • LTC • Labour market policy
Gloria Gutman, PhD Developed the Gerontology Research Centre and Department of Gerontology at Simon Fraser University (SFU) and was Director of both from 1982–2005. She is currently a Research Associate and Professor Emerita at SFU.	• Senior's housing; • LTC; • Health promotion; • Elder abuse; • LGBT aging; • Apocalyptic Demography • Age-friendly hospitals and communities; • Seniors and emergency preparedness; • Increasing advance care planning in marginalized groups and ethnic minorities.

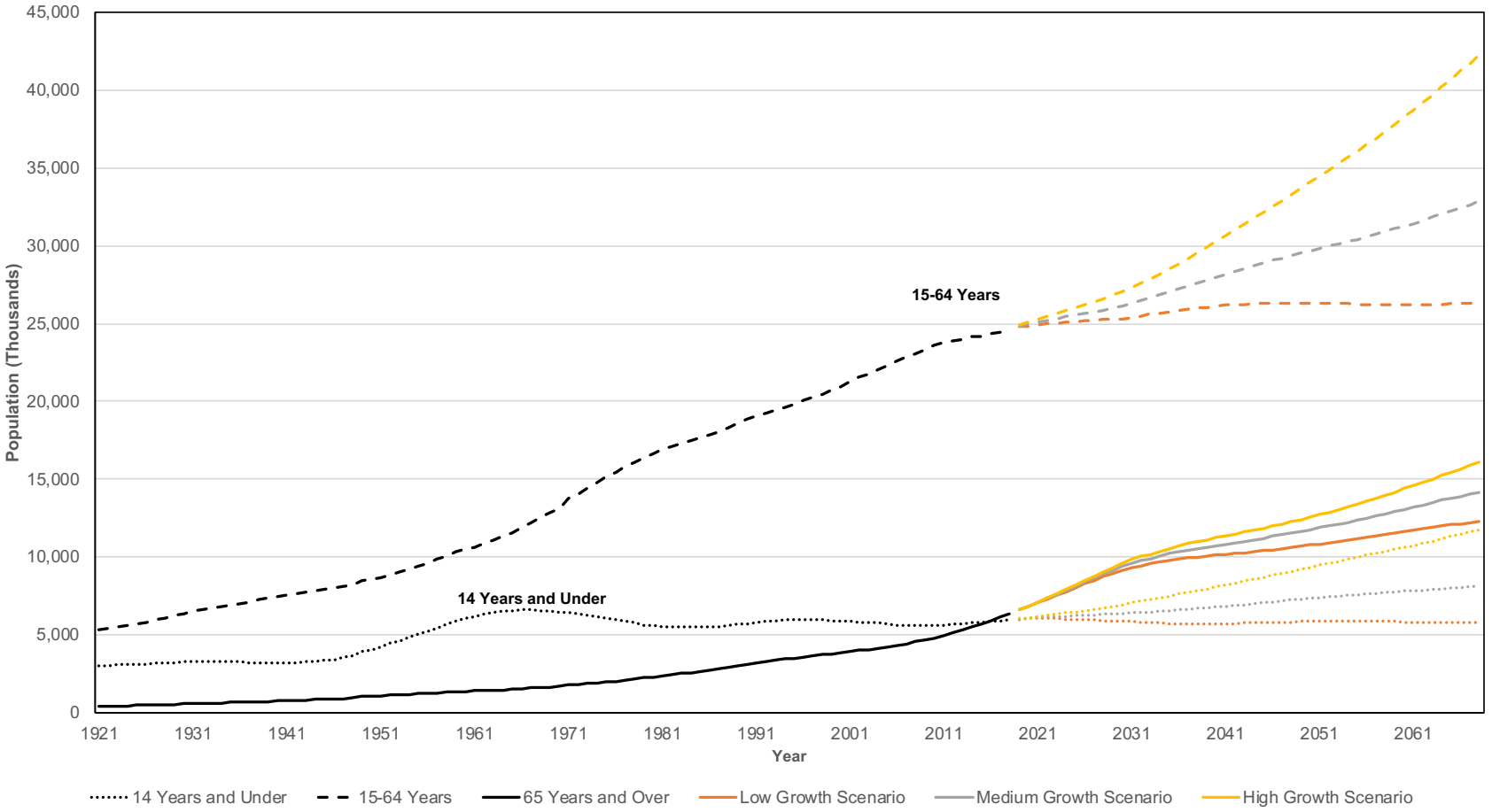
Interviewee	Areas of Expertise
Michele Cook Manager of a not-for-profit assisted living facility in Vancouver. Founder of the Daisy Project. This project developed a framework for a sustainable, palliative approach to LTC that would demonstrate quality improvements to LTC delivery at end of life. The project team was awarded the 2015 Excellence in Quality Award, coping with end of life, by BC Patient Safety and Quality Council (BCPSQC) and also a Vancouver Coastal Health (VCH) People First Award for Excellence in Teamwork. Key contributor to the 2015 Collaborative Practice Evaluation Final Report. This report was submitted to the Michael Smith Foundation for Health Research.	• LTC; • Assisted living management; • Health promotion; • Palliative care; • Senior care harm reduction policies.

Chapter 3. Demographic Projections and the Demand for LTC

In 2018, Canada had 6.4 million seniors (persons aged 65 and over), four times the number recorded 50 years earlier in 1968 (1.6 million), while the overall population increased just 1.8 times over the same period (*Population Projections*, 2019). According to all Statistics Canada's demographic projection scenarios, the proportion of the population aged 65 and over will continue to grow over the next decade. By 2030 (the year when the youngest baby boomers turn 65 years), the proportion of the total population aged 65 and over is projected to increase to between 21.4% (Statistic Canada's slow-aging (SA) scenario) and 23.4% (Statistics Canada's fast-aging (FA) scenario), from 17.2% in 2018. By 2068, the number of seniors is projected to reach between 12.3 million and 16.1 million depending on the scenario (See Figure 1).

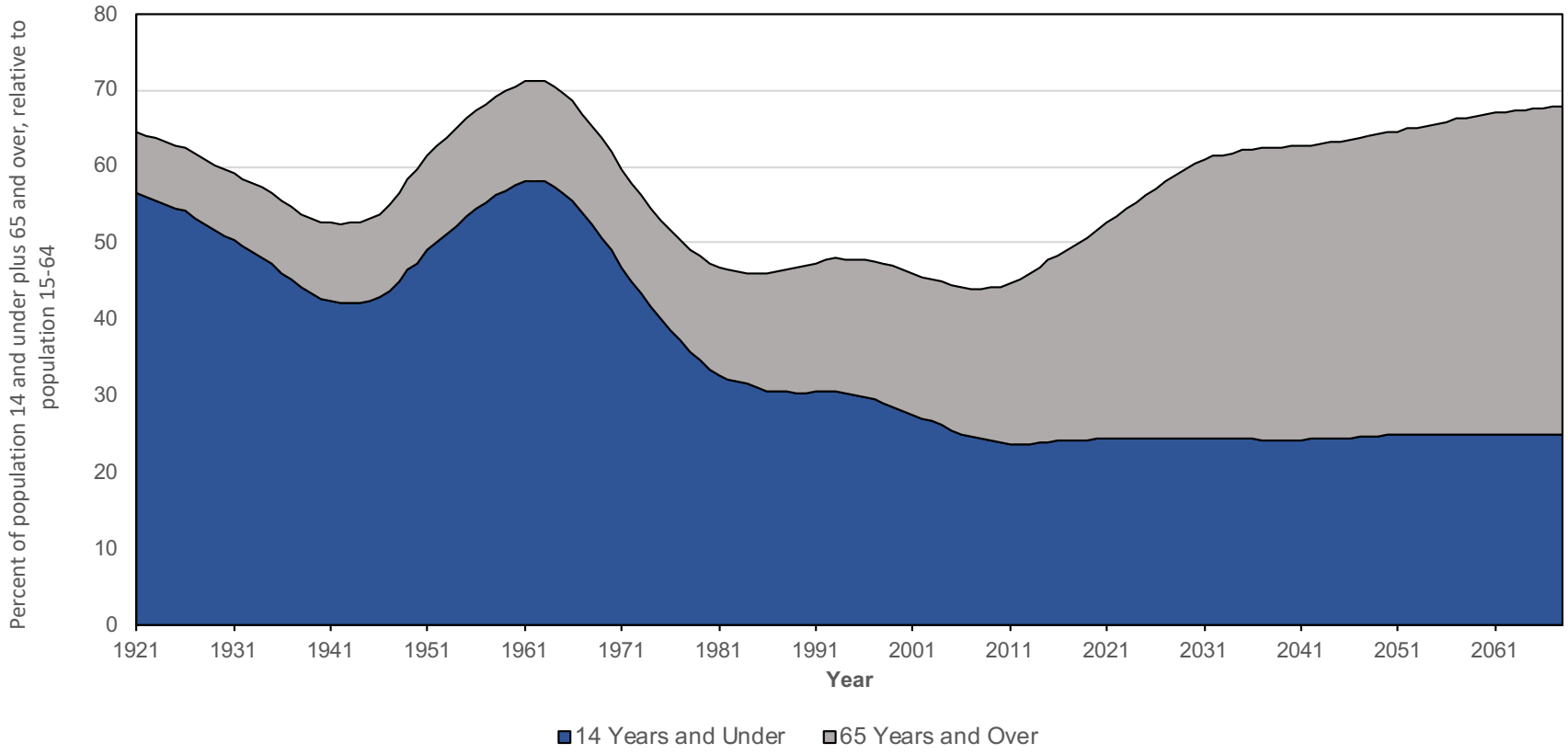
Canada's demographic dependency ratio is projected to increase rapidly up to 2030 as the baby boom cohort gradually exits the 15 to 64 age group and enters the 65 and over age group (See Figure 2). In subsequent years, the dependency ratio is projected to continue to increase, but at a more gradual pace. By 2068, the demographic dependency ratio is likely to reach between 62.8 (scenario SA) and 72.8 (scenario FA) dependent-aged persons per 100 persons aged 15 to 64. A rising dependency ratio means that those of working age, and the overall economy, face a greater burden in supporting the aging population

Figure 1. Population Aged 14 Years and Under, 15-64 Years, and 65 Years and Over, historic (1921-2018) and Projected (2018-2068) According to Low Growth, Medium Growth, and High Growth Scenarios



Source: Statistics Canada (2019).

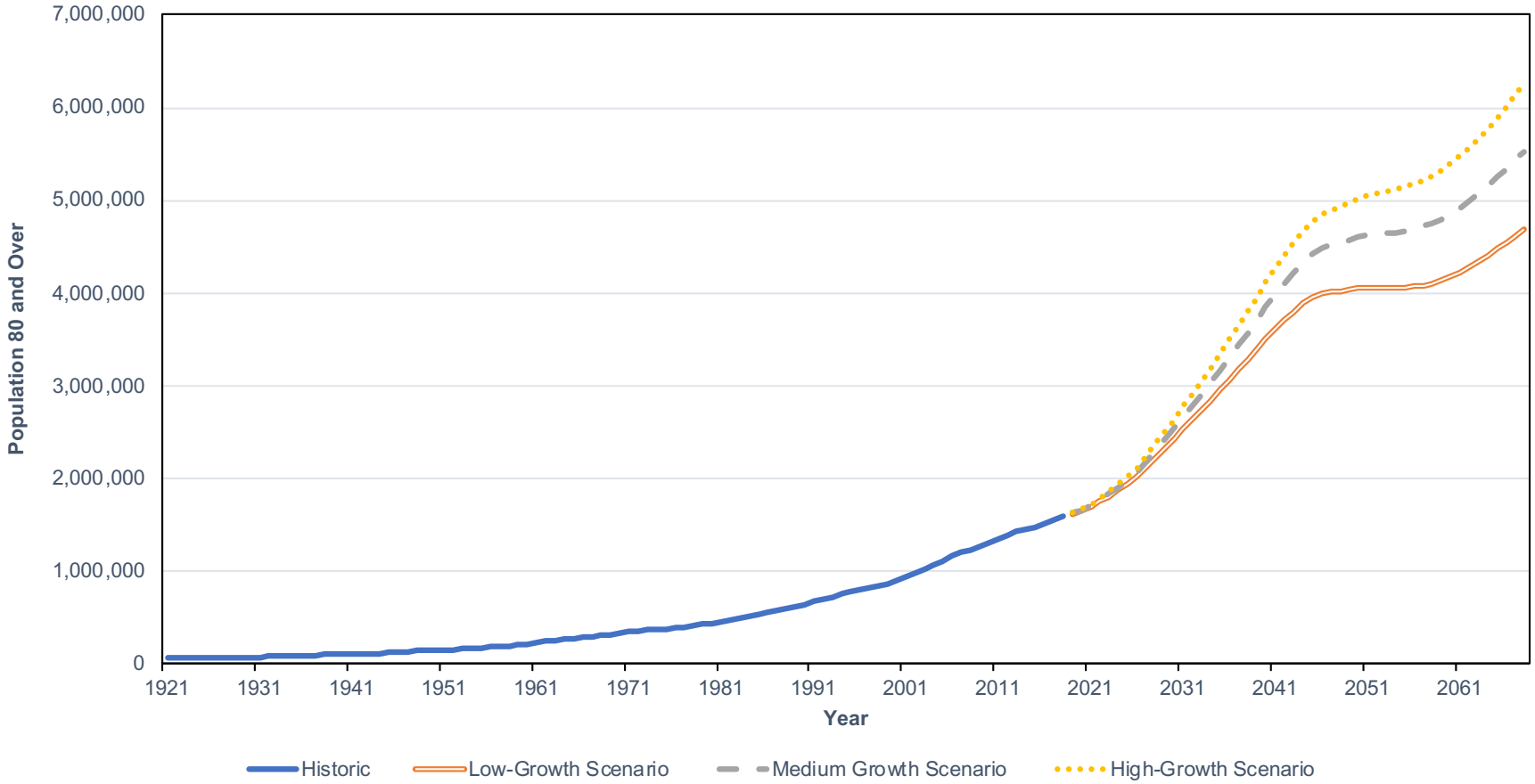
Figure 2. Demographic Dependency Ratio Historic (1921-2018) and Projected (2019-2068) According to Medium Growth Scenario



Source: Statistics Canada (2019).

To predict the potential impacts of population aging on the expected demand for LTC, it is important to note that, on average, LTC demand across OECD countries has been found to remain relatively limited during the first decade of life after age 65 but rises sharply about the time people turn 80 (Blomqvist & Busby, 2014). Under 20 percent of seniors in Canada require any kind of LTC before age 75; by age 85, in contrast, over half require either homecare or facility-based LTC (Statistics Canada, 2013). In fact, in 2014, over half of stays within Canadian LTC institutions were by individuals older than 80 (Blomqvist & Busby, 2014). According to Statistics Canada's demographic projections, the number of persons aged 80 and over has been steadily increasing as a share of the total Canadian population over time. In 2018, the Canadian population had 1.6 million persons aged 80 and over, more than five times as many as 50 years earlier in 1968 (302,100). The members of the baby-boom cohort will enter this age group between the years 2026 and 2045. This phenomenon, and to a lesser extent, the anticipated gradual increase in life expectancy, is projected to cause the number of persons aged 80 and over to increase rapidly during this period in all scenarios, reaching between 4.0 million (scenario LG) and 4.8 million (scenario HG) by 2045 (See Figure 3). From 4.3% of the total population in 2018, persons aged 80 and over will represent a peak of 7.9% of the population in 2045 according to the slow-aging (SA) scenario. In contrast, in the fast-aging (FA) scenario, the number of persons aged 80 will continue to increase as a proportion of the total population throughout the projection, representing 12.3% of the population by 2068.

Figure 3. Canadians Aged 80 and Over Historic (1921-2018), and Projected (2018-2068)



Source: Statistics Canada (2019).

On top of the rising dependency ratio and the projected continued growth in the number of seniors, particularly the projected rise in the share of the population aged 80 and over, Canada is also facing lower fertility rates and socio-economic shifts that will decrease the availability of support from family members acting as unpaid caregivers – a primary care source for Canada's senior population today (MacDonald et al, 2019). In fact, care supplied at home currently exceeds care provided by the formal healthcare sector by a ratio of over three to one, at little or no direct cost to the public purse (Ibid). While it is likely that this will continue to be the case in future years, a growing number of Canadians will also require LTC services provided by paid workers and professionals. In the absence of policy changes, this growing number of Canadians requiring LTC services will greatly increase LTC costs.

Chapter 4. Projecting Future LTC Costs

Population aging is a trend that is present in almost all other OECD countries, whose spending on LTC is projected to double, or even triple, over the next 50 years (OECD, 2011). As the number of seniors receiving institutional LTC is a relatively small proportion of seniors below age 75, the financial burden that LTC will likely impose on Canadian society over the next 5-7 years is considered to be manageable (Blomqvist & Busby, 2014). However, when baby boomers enter into the age 80 and older category (between 2026 and 2040), LTC costs will increase at a rapid rate (Ibid). In response to the predicted rise in costs, Canadian researchers have attempted to estimate just how much costs will grow and the resulting public and private burden.

4.1. C.D. Howe Institute

Combining population forecasts with age-specific utilization rates, the C.D. Howe Institute released a report in 2014 that estimated, under current systems of delivering and paying for LTC, the annual average cost of institutional LTC in Canada was roughly $60,200 per recipient in 2014 dollars and formal homecare costs were about $18,000 (Blomqvist & Busby, 2014). The C.D. Howe Institute projected that total annual LTC costs will roughly triple over the next 40 years, growing from around $69 billion in 2014 to around $188 billion in 2050, in inflation-adjusted dollars. Public LTC costs are estimated to grow from around $24 billion in 2014 to around $71 billion in 2050. In aggregate, the private burden is anticipated to be even higher, growing from around $44 billion to about $116 billion over the same period of time. Looked at another way, the average public cost of LTC rises from $690 per Canadian in 2014 to about $1,470 in 2050; annual private per-capita LTC costs rise from approximately $1,240 to $2,390 over that same time period.

The above projections were made using the assumption that Canadian provincial governments will fund future LTC services in ways similar to how they currently fund these services and how they have done so in previous decades. Further, as there is no single authority that supplies statistical information on the kinds of LTC that are provided for different age groups in Canada, the C.D. Howe Institute combined data from several publicly available sources including: Statistics Canada’s population

projections for seniors – version M1/the medium growth assumptions, Statistics Canada census and survey results, Canadian Institute for Health Information (CIHI) data and Canadian Medical Association estimates in the development of their projections. It is important to note that these projections, although developed taking into consideration a comprehensive set of components, have been made assuming that patterns will remain unchanged. It is highly unlikely that this will be the case. For example, patterns have already begun changing and are likely to continue changing with regards to home-based care use versus institutional LTC. There has been an increased policy emphasis across Canada on the promotion of home-based care – a less expensive and preferred option of care (Grignon & Bernier, 2012). That being said, these estimates serve their purpose of displaying the need for more attention to the projected aggregate cost of LTC in Canada.

4.2. Canadian Life and Health Insurance Association (CLHIA)

In 2014, the CLHIA published a paper that examined the resources that will be needed in order to support the baby boomers as they pass through old age in the next 35 years (*CLHIA Report*, 2014). The paper concludes that a significant funding gap exists. According to CLHIA projections, the present value of all costs (in 2014 dollars) of providing LTC over this timeframe will amount to almost $1.2 trillion. This is roughly equivalent to the market value of all public and private retirement assets held by Canadians in registered pension plans in Canada in 2009. According to the paper, 2014 levels of government program and funding support for LTC will cover about $595 billion of this total cost. This leaves a funding shortfall of $590 billion to be financed through new government initiatives or individual savings by Canadians. An amount equivalent of 94 percent of all 2014 individual registered savings plans in Canada.

According to the paper, it is commonly argued that the projected funding shortfall should be eliminated by an increase in government programs and spending. However, according to the CLHIA, the annual shortfall between the total expected future LTC costs and projected government funding is expected to grow significantly over time. In order for governments to cover this shortfall, there would need to be an immediate and permanent increase to both personal and corporate taxes, at all levels of government, of roughly 6.4 percent. It was concluded that this approach would not be practical or

desirable given the 2014 economic and fiscal environment, as well as the significant additional burden that this would place on the younger working-age population. Given the pandemic-related economic downturn and the intergenerational equity concerns, one can conclude that the CLHIA would continue to find this approach impractical today.

With regards to the cost projections made within this paper, LTC costs were calculated over the period 2012 to 2047 based on the forecasted life expectancy of baby boomers. Total estimated costs consist of LTC provided through: hospitals, LTC facilities, and homecare. These components were calculated as follows:

a) care in hospitals = number of seniors receiving care x inflation-adjusted per- patient cost.
b) care in LTC facility = number of seniors receiving care x cost x inflation.
c) homecare = number receiving care * cost * inflation.

Each component was calculated as the sum of future cash flows over the expected time period and then discounted to provide the present value of costs in current dollars. The three components sum to a total estimated LTC cost ($1.2 trillion). Within the paper, it was acknowledged that the costs that were assigned to the different components of LTC are likely to rise over the coming years and therefore, the total estimated cost of LTC is a conservative estimate. In order to estimate the required increase in taxes to close the identified $590 billion funding shortfall, the CLHIA calculated the funding shortfall per year between 2012 and 2047 and then estimated the total personal and corporate tax revenues for all levels of government in Canada using Statistics Canada data over that same period. The percentage increase in required taxes from all levels of government was calculated by dividing the total LTC shortfall by total forecast government tax revenues.

4.3. National Institute of Aging

A 2019 study published by the National Institute of Aging (NIA) contained a detailed series of projected costs for LTC (MacDonald et al., 2019). This study split costs up into four categories: 1) public government costs, 2) personal costs for seniors, 3) economic value of unpaid care and 4) joint public and personal costs of LTC. This study utilized a microanalytic approach, projecting the Canadian population over the next 30

years (using Statistics Canada's LifePaths Model), and multiplying LTC service utilization by unit costs. With regards to unpaid care, this form of care was valued at an estimated replacement cost of care.

The study found that in 2019, approximately 93% of seniors (aged 65+) were in private homes/residences, 2% in retirement residences and 5% in nursing homes. By 2050, the study projected that there will be roughly 75% more seniors, with 90% living in private homes/residences, 3% in retirement residences and 7% in nursing homes. With regards to homecare, publicly-funded homecare hours amounted to approximately 18% of all homecare hours, with privately-paid hours at 7%, and unpaid hours at 75% in 2019. In the study, all homecare hours were projected to more than double by 2050 – from approximately 300,000 unpaid, 70,000 publicly-funded and 30,000 privately-paid hours in 2019, to approximately 645,0000 unpaid, 150,000 publicly-funded and 75,000 privately-paid hours in 2050.

The NAI projected that the total public costs for residential facilities and publicly-funded homecare were approximately $22 billion in 2019, which translated into 9% of total annual personal income tax revenue (federal + provincial) and 2.1% of aggregate wages. The NAI has projected that between 2019 and 2050, the cost of public care in residential facilities and publicly-funded homecare will more than triple, growing from $22 billion to $71 billion annually (in constant 2019 dollars). According to the study, these costs will roughly double relative to the macroeconomy, increasing from 9% of personal income tax in 2019 to 19% by 2050, and from 2% to 4.3% of aggregate wages. Further, it is estimated that if all unpaid hours of homecare were fully publicly-paid – priced at $30/hour (in 2019, and growing in line with average wages at assumed 1.1% per annum) – this would add $27 billion to public costs by 2050. In this case, the public sector cost would grow instead to $98 billion. This represents nearly a quarter of all projected personal income tax revenue (provincial + federal) and 6% of aggregate wages.

According to this study, although the projected increase in costs for the public purse is greatly disconcerting, it is not the only component of the problem. Pressure on unpaid care will also increase as the baby boomers get older and family sizes decline, largely due to reductions in Canadian fertility rates. In 2019, about 75% of total homecare hours were met by unpaid caregivers. Only 6% of Canadian seniors in homecare received formal, publicly-funded care. The number of seniors requiring unpaid

care is projected to increase by 120% between 2019 and 2050, from 345,000 to 770,000. The average number of hours needed will grow from 290 hours/unpaid caregiver/year in 2019, to 415 hours/unpaid caregiver/year in 2050. This growth in the number of seniors requiring unpaid care, as well as the increase in the number of hours is troublesome considering that the baseline projections of this study show that by 2050 there will be approximately 30% fewer close family members (spouses and adult children) who would potentially be available to provide unpaid care. This means that Canadian seniors who do not have unpaid support will have to pay out of pocket. Those who are unable to pay out of pocket for LTC services are at risk of greater unmet care needs.

This NAI study made sure to note that the projections made within are not to be considered firm predictions that take into account every angle of the policy problem. For example, in the discussion of unpaid homecare the NAI projected the number of children. However, the study did not consider the geographic proximity of the children of unpaid caregivers – which plays a major role in their capacity to provide daily care. Further, higher female participation in the formal labour market and greater expectations of the government to provide care are also likely to contribute to a decline in the availability of unpaid caregivers. That being said, the results of the study provide a reasonable view of the future. A view that is cause for concern.

It is clear from the projections above that there is a need for advance planning and policy on whether current Canadian financing models are able to deal with the future cost pressures of this sector.

Chapter 5. LTC Financing Policy | Jurisdiction

On the federal level, the Canada Health Act (CHA) encompasses 'extended healthcare services,' which includes aspects of LTC provided in designated buildings (nursing homes, facility-based LTC) and the health aspects of homecare and ambulatory care services (Sinha et al., 2019). The CHA also sets out the criteria and conditions the provinces must fulfill in order to receive federal transfer payments under the Canada Health Transfer (CHT) (Ibid).

Canada has a mixed system where some costs of LTC are covered by Canadian governments and others are met privately or by unpaid caregivers (Worsfold et al., 2018). In 2019, just under three-quarters of LTC costs in Canada were paid for by public sources – accounting for 1.9 percent of GDP[1] (*Health Expenditure*, 2020). The remaining amount was paid through private insurance or direct payments, mainly for accommodation fees (Worsfold et al., 2018). The mixed system makes it challenging to navigate the regulations and financial eligibility requirements associated with LTC within each Canadian province. However, there exists a series of broad principles that shape LTC funding policy across Canada:

- All costs associated with medically necessary services are covered by the provincial government;
- Those seeking LTC bear some responsibility for accommodation costs;
- Public subsidies of accommodation costs are targeted based on ability to pay;
- Provinces apply a limit to LTC payments by the elderly, such that the elderly retain some of their income and assets;
- Payments should take into account the needs of other family members.

These principles define a non-universal safety net model of targeted universalism. Within this model, Canadian provinces subsidize LTC out of general revenues and offer needs-based programs that are universal in the sense that they are available to all residents who meet the needs-tests criteria (Blomqvist & Busby, 2012). These programs, however, are targeted in the sense that recipients' co-payments are

[1] In 2019, overall health spending represented 11.6% of Canada's GDP (*Health Spending*, n.d.).

means-tested (Ibid). In defining recipients' ability to pay their share, all provinces take into account their declared income – Quebec, Newfoundland and Labrador also include assets (Ibid).

5.1. Provincial Variation | Public Private Shares

Each Canadian province has developed a series of subsidized LTC programs that vary in the extent of public subsidy as well as the ease of access and availability of services (Blomqvist & Busby, 2012). In deciding on the subsidy of LTC, provinces distinguish between funding "direct" services (case management, nursing care, physicians' services) and the associated charges for shelter, food, and housekeeping (Ibid). The co-payments are intended to cover all or portion of the costs of living that recipients would be paying if they still lived in the community (Ibid). Those staying in a government-subsidized residential facility or using subsidized homecare services must pay these co-payment costs out of pocket or through private supplementary insurance. Despite its availability, private insurance is not a popular product in Canada, with only about 1 percent of Canadians age 65 and older owning private LTC insurance (Ibid).

Average private charges for subsidized facility-based care vary across the provinces, however, charges tend to be the highest in British Columbia and the Atlantic provinces (*Table 2*). In each province, minimum private facility-based costs are closely integrated with the federal public income-support system for seniors (Blomqvist & Busby, 2012). 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 (Ibid). Each individual living in a residential facility is also entitled to a minimum monthly allowance for personal expenses (Ibid). Those with incomes greater than basic OAS/GIS levels pay higher facility fees, up to a specified maximum (Ibid). In most provinces, the clawback rate is 100 percent, meaning that recipients must pay an additional dollar in fees for each dollar of income above the basic OAS/GIS threshold (Ibid).

Alberta, Newfoundland and Labrador illustrate the variation in approaches to private LTC charges. In Alberta, a single individual receiving care in a subsidized institution pays a maximum of roughly $16,200 annually out of their 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 cut-off is clawed back, generally at around 100 percent, until the maximum charges are paid in full (Blomqvist & Busby, 2012). 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 their assets do not exceed $10,000 (Ibid). 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 (Ibid).

Although most provinces increase charges to clients with income above OAS + maximum GIS 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 (Blomqvist & Busby, 2012). This allows residents of that province who need facility-based LTC to keep a larger share of their income, as well as reducing the 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 LTC facility, to avoid dollar for-dollar claw backs (Ibid).

Table 2. Facility-Based Care | Conditions on Government Subsidy for Private Charges

Province	($annual)	Single Individual	Asset Deduction?	One Spouse in Care	Asset Deduction?
BC	Regular charges: 36, 200 Reduced charges: 11,200 Minimum annual allowance for residents: 3,900	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. Assessed based on net income.	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
On	Regular charges: 19,400 Minimum charges: 12,600 Minimum annual allowance for residents: 1,560	Reduced charges apply when: OAS/GIS max < annual income < $15,00. 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. Assessed based on half of joint net income. Spouses in community can retain a reasonable income. Means that minimum charges can fall below OAS/GIS single max level.	No

Province	($annual)	Single Individual	Asset Deduction?	One Spouse in Care	Asset Deduction?
AB	Regular charges: 16,200 Minimum charges: 11,000 Minimum annual allowances for residents: 3,180	Reduced charges apply when: OAS/GIS max < annual income < $24,600. Income above OAS/GIS max assessed at ~ 100% until $24,000. Assessment based on gross income.	No	Reduced charges apply when: OAS/GIS max < annual joint income < $40,000. Spouses in community can retain reasonable income. Means that minimum charges ca fall below OAS/GIS single max level.	No
SK	Regular charges: 22,900 Minimum charges: 12,000 Minimum annual allowances for residents: 2,544	Reduced charges apply when: OAS/GIS max <annual income < $37,000. Income above OAS/GIS max assessed at 50% until #37,000. Assessment based on gross income.	No	Same formula applies to half of joint family income. Assessment based on half of joint gross income.	No

Province	($annual)	Single Individual	Asset Deduction?	One Spouse in Care	Asset Deduction?
MB	Regular charges: 26,800 Minimum charges: 11,400 Minimum annual allowance for residents: 3,324	Reduced charges apply when: OAS/GIS max < annual income < $15,000. Income above OAS/GIS max assessed at 100% until $30,100. Assessment based on gross income.	No	Reduced charges apply when: $45,000 < annual income < ~$60,400. Family income above $45,000 assessed at 100% until ~$60,400. For those paying the minimum charges, partner allowed to retain at least $18,000 for living expenses. For those paying the minimum charges, partner allowed retain at least $30,240 for living expenses.	No
QC	Regular charges: 12,800 Minimum charges: 10,400 Minimum annual allowance for residents: 2,268	Assuming no assets, reduced charges apply when: OAS/GIS max < annual income < $15,000. Income above OAS/GIS max assessment at 100% until $15,000. Assessment based on gross income.	Yes, claw backs 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 fall below OAS/GIS single max level.	Yes, claw backs for assets kick in when income > $40,000

Province	($annual)	Single Individual	Asset Deduction?	One Spouse in Care	Asset Deduction?
PEI	Regular charges: 26,500 Minimum charges: 14,000 Minimum allowance for residents: 1,236	Reduced charges apply when: OAS/GIS max < annual income < $27,000. 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 the community can retain reasonable income. Means that minimum charges can fall below OAS/ GIS single max level.	No
NL	Regular charges: 33,600 Minimum charges: 13,500 Minimum annual allowance for residents: 1,800	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 individual.	Reduced charges apply when: OAS/GIS max < annual income < ~$75,000. Family income above OAS/GIS max, plus living allowance for spouse in the 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.

Province	($annual)	Single Individual	Asset Deduction?	One Spouse in Care	Asset Deduction?
NB	Regular charges: 30,300 Minimum charges: 1,296 Minimum allowances for residents: 1,296	Reduced charges apply when: OAS/GIS max < annual income < $31,500. Income above OAS/GIS max assessed at 100% until $31,000. Assessment based on net income.	No	Reduced charges apply when: OAS/GIS single max < annual family income < ~$67,000. Family income above OAS/GIS single max assessed at ~$67,000. Assessment based on net family income. Spouses in community can retain reasonable income. Means that minimum charges can fall below OAS/GIS single max level.	No
NS	Regular charges: 36,100 Minimum charges: 12,500 Minimum annual allowance for residents: 2,760	Reduced charges apply when: OAS/GIS max < annual income < $42,000. Income above OAS/GIS max assessed at 100% until $42,000. Assessment based on net income. Residents can request lower level of care at max of $22,300 annually.	No	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. Assessment based on half of joint net income. Spouses in community can retain at least $16,974/year. Means that minimum charges can fall below OAS/GIS single max level.	No

Source: C.D. Howe Commentary 367 – Source: Fernandes & Spencers (2010); Manulife (2011); and miscellaneous government documents.

5.2. Care Providers

In Canada, the provision of subsidized LTC is almost entirely in-kind rather than in cash or vouchers (Blomqvist & Busby, 2012). Co-payments for both homecare and institution-based services are fixed, and the provincial government, not the recipient, pays the residual costs of services (Ibid). In some cases, homecare is supplied through persons employed in government agencies, but more commonly governments contract with private firms to supply these services (Ibid). Provincial guidelines set maximum limits for the amount of homecare people can receive (See *Table 3*) (Worsfold et al., 2018). In Canada, both federal and provincial policies to fund home and community-based LTC vary. Currently, five of the ten provinces have implemented income-based home and community-based care mechanisms to recover a portion of the costs of providing an individual home and community-based care based on their actual income (Columbo et al. 2011). In 2019, the federal government committed $6 billion over four years (starting in 2020) to close gaps in healthcare, with an emphasis on both improving and increasing access to homecare (Gatehouse, 2019). As a percentage of health spending, in 2016, homecare averaged 4 percent of all health costs, ranging from a high of 6.8 percent in New Brunswick and 6 percent in Ontario to a low of 2.4 percent in Alberta (Ibid). Although some subsidized LTC recipients reside in provincially owned hospitals, the majority are cared for in private nursing homes that derive their revenue from provincial government plans (Ibid). Private not-for-profit, public, and private not for-profit providers of government-subsidized homecare services and facility-based LTC exist across the country.

5.3. Financial & Service Flows in LTC

Subsidized LTC facilities receive two funding streams from government: one associated with nursing and direct healthcare services, and another for accommodation costs (such as lodging, housekeeping and maintenance). In principle, the total LTC facility charge less the subsidy should not exceed the maximum private charge (Blomqvist & Busby, 2012). The provinces are responsible for setting individuals' co-payments, which as illustrated in *Table 2*, are reduced as a recipient's income falls below a certain level.

5.4. Eligibility Tests

Under current provincial frameworks, an individual's eligibility for different kinds of LTC services is determined according to a single-entry system based on assessments by health professionals and the availability of providers (Blomqvist & Busby, 2012). In general, admission to provincially subsidized support programs requires that the recipient face complex ongoing care requirements, have limited informal home support, and cannot access affordable care (Ibid). 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 (Ibid).

Table 3. Maximum Hours of Home Service in Selected Provinces

Province	Maximum Hours of Service and Funding	Government Subsidy?	Asset Deduction?
ON	120 hours in the first 30 days of service and 90 hours a month for personal support services.	No income test.	No
MB	55 hours per week of homecare attendant services.	No income test.	No
QC	15 hours per week.	Income assessment may reduce private homecare charges. Income assessment based on family composition and annual income. Income assessed at 100% for singles earning over $25,000; $35,000 for couples.	Yes
NB	215 hours per month for home support.		
NS	100 hours of home support every 28 days.	Income assessment may reduce private homecare charges. Income assessment based on grid that includes household size and annual income. Private charges have ceiling.	No
PEI	28 hours a week, or 3 visits.	No income test.	No
NL	$3,490 per month for home support to pay for: 4 hours a day of personal care; Up to 1 hour a day for meal preparation and 2 hours a week for homemaking when a caregiver doesn't live with the client; 2 hours a week of homemaking when a caregiver lives with the client; Respite services for caregivers living with someone who needs 24-hour care or supervision.	Income assessment may reduce private homecare charges. Income assessed at different rates, up to 15 percent of total income, if: $13,000 < income < $150,000. Maximum subsidy (aged 65+) is $32,295 per year. Annual exempted income is $21,000 for couple.	Yes, on liquid assets. $10,000 for single individual; $20,000 for couple.

Source: Levels of Care Expert Panel – 2017 & C.D. Howe Commentary 367.

The structure of Canadian federalism, the division of powers, allows provinces to deliver care in accordance with conditions and preferences of the citizens of that particular province (MacDonald et al, 2019). Further, the federal government has a nationwide pool to collectivize and spread the financial risk of LTC (Ibid). Worth mention, multiple jurisdictions provide venues for policy experimentation and the diffusion of best practices (Ibid). That being said, many of those concerned about the sustainability of LTC in Canada question whether these advantages are realized. In a context of population aging, declining fertility rates and, more recently, declining provincial tax revenues caused by the pandemic-related economic downturn, Canadians want to know what is expected of them in terms of the rising costs and whether provincial funding arrangements are currently adequate.

Chapter 6. Canada in an International Context | Jurisdictional Scan

The increasing pressure placed on LTC is not unique to Canada. Population aging, declining fertility rates, and increased expectations for high-quality care are realities faced by all high-income countries (Colombo, 2011). All of these factors are pushing up the cost of LTC across OECD countries and raising the question of who should cover the rising costs in policy discussions. As stated in the previous chapter, there is variation across Canadian provinces in how LTC is funded; however, all provinces use the same basic model of financing and in-kind services provision (Blomqvist & Busby, 2012). Other OECD countries have developed different strategies to make LTC services more affordable and efficient. This chapter highlights a few international examples to consider in the Canadian context. A full description detailing the approach of each individual jurisdiction can be found in Appendix A.

6.1. Summary of International Models

Schemes that allow seniors to choose between care in-kind, through cash subsidy or restricted cash transfers, have become a widely accepted feature in most developed nations as more emphasis has been placed on independent living or self-directed care (Blomqvist & Busby, 2016). These schemes, common within Europe, are becoming a larger part of LTC across OECD counties (Columbo et al. 2011). The rationales for introducing a greater reliance on cash-based, self-directed models vary. However, they commonly include:

- Increased recognition of diversity in care needs;
- Homecare substitution;
- The need to put health costs on a more sustainable path;
- The need to ensure choice;
- The desire to better incorporate informal caregiving into care plans;
- The desire to introduce more competition into care markets;
- Importance of promoting independence among the elderly.

Although there are not yet any studies showing improved cost-efficiencies from moving to self-directed and increasingly cash-based systems, satisfaction levels have gone up considerably where cash subsidies have been introduced (Columbo et al. 2011). There is considerable variation in how countries have gone about introducing self-directed, cash-based models in terms of means-tests, the way in which care needs are assessed and how to ensure quality through restrictions and oversight of the way moneys are spent (Blomqvist & Busby, 2016). Germany, as part of their universal, public LTC insurance scheme, has opted to deliver cash benefits with few restrictions, but set the size of the cash benefit below the value of in-kind services as a way of pushing individuals towards the in-kind option (Ibid). In contrast, France, as part of their mixed system of income-related universal benefits, gives cash benefits but with greater restrictions, making them more like vouchers (Ibid). This is also the approach taken by Japan as part of their universal, public LTC Insurance (LTCI) scheme (Ibid).

Germany and Japan have been able to provide LTC to a large proportion of seniors without spending much more for their LTC systems because they spend more on home and community-based care than on facility-based LTC as part of their self-directed models (Peng, 2020). As shown in Table 4, Japan ranks first in the health domain with a life expectancy of 26 additional years at the age of 60, with over 20 years of those years expected to be healthy according to Global AgeWatch Index. Older adults in Japan report high satisfaction with social connectedness, safety, and civic freedom (Drummond et al., 2020). Germany ranks high in the capability domain of the Global AgeWatch Index, with the second-highest educational attainment rate among older adults, as well as in social connectedness, elder satisfaction, and civic freedom (See Table 5). Life expectancy and healthy life expectancy are strong as well (Drummond et al., 2020). Much of the literature on the topic of LTC financing attributes these positive ageing statistics to the ease of ability for seniors to select home and community-based care as part of these jurisdictions self-directed LTC models.

Table 4. Global AgeWatch Report Card | Health Status Domain (2015)

AgeWatch	Health Status | Indicators data
Canada	Life expectancy at age 60: 25
	Healthy life expectancy at age 60: 18
	Relative psychological/mental wellbeing: 100.0
Germany	Life expectancy at age 60: 24
	Healthy life expectancy at age 60: 17.8
	Relative psychological/mental wellbeing: 101.2
Japan	Life expectancy at age 60: 26
	Healthy life expectancy at age 60: 20.3
	Relative psychological/mental wellbeing: 87.8

Source: Global AgeWatch Index 2015

Notes:
Life expectancy at age 60: The average number of years a person aged 60 can expect to live.
Healthy life expectancy at age 60: The average number of years a person can expect to live in good health.
Relative psychological/mental wellbeing: % of people over 50 who feel that their life has meaning compared with people 35-49 who feel the same way. This indicator measures self-assessed mental well-being.

Table 5. Global AgeWatch Report Card | Capability Domain (2015)

AgeWatch	Capability Domain| Indicators Data
Canada	Employment of older people: 60.5
	Education attainment: 84.6
Germany	Employment of older people: 63.5
	Education attainment: 93.4
Japan	Employment of older people: 66.8
	Education attainment: 74.1

Source: Global AgeWatch Index 2015

Notes:
Employment of older people: % of the population aged 55-64 that are employed.
The indicator measures older people's access to the labour market and their ability to supplement pension income with wages, and their access to work related networks. The employment rate is a proxy for the economic empowerment of older people.
Education attainment: % of population 60+ with secondary or higher education. Education is a proxy of lifetime accumulation of skills and competencies that shows social and human capital potential inherent among older people.

Some Canadian provinces have begun efforts to move away from a one-size-fits-all approach to LTC provision. For example, Quebec has promoted the provision of more self-directed care by encouraging older Quebecers to organize and purchase the homecare and support they need with the help of both a Financial Assistance Program for Domestic Help Services and a refundable tax credit for homecare services for those over 70 years of age (Sinha et al., 2019). Manitoba also provides a refundable tax credit for homecare services, as well as subsidies for purchasing additional care from private agencies as a way to better meet their individual LTC needs (Ibid).

Although some provinces have recognized the potential benefits of this approach, Canada as a whole is still an outlier in terms of offering self-directed care and shifting more care resources toward patients' homes or in the community (Blomqvist & Busby, 2016). In Canada, 82 percent of LTC spending goes to facility-based care (versus 11 percent to in-home care and 7 percent to community-based LTC), whereas in Japan and Germany, facility-based LTC takes up 66 percent and 41 percent of the total LTC spending, respectively (Ibid). Many Canadian seniors remain in alternative level of care beds in hospitals for long periods and are then placed in LTC homes (Drummond et al., 2020). Between 10% and 20% of seniors in LTC facilities could do well with homecare, a living arrangement that is not only preferred by the vast majority of Canadian seniors, but would also be a lot less expensive for Canadian seniors and society (Ibid). Living in an acute care hospital is the most expensive care option available for seniors, ringing in at almost $1,000 per day (Ibid). LTC-homes are less expensive at approximately about $142 a day (Ibid). Formal home care can provide most of the services needed to support ageing well for around $45 per day (Ibid).

Although there are benefits to embracing self-directed and increasingly cash-based systems, there are also concerns. For example, the adequacy of coverage in France. Even with supplementary private insurance, the French receive a fairly limited level of coverage (Doty et al., 2015). In 2015, the dependency costs averaged €2,500 ($3,400) per month €3,500 ($4,760) in cases of "severe" dependency) – with an average payout of €500 ($680) from the Allocation Personnalisée d'autonomie (APA) and €300 ($408) from private LTCI. Thus, the APA and supplemental insurance together cover €800 ($1,088), only about 32% of the average monthly cost of care, leaving many reliant on safety-net programs operated at the département level, and the remainder drawing on private resources (Doty et al., 2015). In addition, although greater consumer choice is

often cited as a benefit, concerns have been raised regarding the asymmetric and imperfect information available for consumers to make informed choices (Colombo, 2011). Further, in schemes that allow seniors to choose between care in-kind or through cash and voucher programming, there is a concern that providers may discriminate prices among those who use a voucher and those who do not, or they may discriminate across different users (Ibid). Additionally, in some rural areas in Nordic countries, voucher schemes have proved unfeasible due to lack of private providers (Ibid). As for urban areas, some municipalities are dominated by an oligopoly of private providers, hindering free competition (Ibid). Lastly, another drawback relates to the higher administrative work after the implementation of a voucher scheme (Ibid).

A concern related to the adoption of a LTCI model is that a self-funding mandate can be difficult to sustain in the face of an aging population, as revenues vary based on who is in and out of the labour force, as well as the demographic profile of the working population (Nadash et al., 2018). It is very difficult to accurately forecast LTC demand and associated expenditures. That being said, from 1994 through the present day, Germany has been successful (Ibid). Despite this success with forecasting LTC demand, like France, the adequacy of coverage in Germany has been a concern. Because LTC insurance is intended to make available only a baseline of care, many households purchase supplementary private LTC coverage (Torjman, 2013). As of 2009, more than 1.6 million Germans owned additional private insurance (Ibid). Another concern relates to revenue generation. It can be politically difficult to increase revenue by raising premiums set by legislatures (Nadash et al., 2018). This is why Germany's most recent reforms, which increased premiums and index-link benefits, are significant (Ibid). Finally, since Germany introduced the option to receive care either in the form of a cash voucher or through in-kind services, the government has found it difficult to regulate how people use the funds and purchase services from the private market (I. Peng, speech, November 18, 2020). It is common in Germany for private families to employ migrant care workers. This has created a dual labour market. Those care providers delivering LTC services within regulated institutions/facilities and care provision networks have set wages, monitored working conditions and their employment is largely protected by labour regulations (Ibid). The migrant care workers fall outside of this category. In response, the German government has been trying to create more regulations around

care provision, particularly focusing on creating criteria around what certifications are necessary to become a qualifying LTC provider (Ibid).

Timing is also an important consideration. Germany created a mandatory social LTCI in 1995 (Blomqvist & Busby, 2014). While the cost pressures of this LTCI insurance plan are stressing the government budget in Germany today, the fact that their system to finance LTC was put in place back in 1995 means that today's boomer population has been contributing to the plan for some time (Ibid). While the cost that today's seniors in Germany are asking future taxpayers to bear is greater because the boomer generations are relatively large, they can claim that the extent of the intergenerational inequity is lessened because they have paid into the programs in the past (Ibid). Canada's boomer generation cannot make this claim, and the extent of intergenerational inequity from introducing a large public LTC insurance program today would be increased by the fact that the retiring generations who would benefit are relatively large and projected to live much longer than the generations before them (Ibid).

As for Japan, over the years, eligible services have been slowly cut back to keep up with the growing demand and fiscal constraint (Glauser et al., 2015). In 2000, the year after the program was launched, 2.2 million Japanese people required LTC services (Ibid). By 2013, the number accessing LTC had more than doubled, to 5.6 million, according to Japan's Ministry of Health, Labour and Welfare (Ibid). That said, some argue that Japan has been able to maintain the LTC insurance scheme for 15 years despite a doubling in demand, and this shows that LTC insurance may (with appropriate adjustments) be sustainable for other countries facing similar struggles. Proponents of the introduction of a LTC insurance scheme in Canada argue that a separate designated fund for LTC would represent a substantial advance over Canada's present system, a patchwork of programs supported through tightly-stretched provincial/territorial budgets and user fees (Ibid). Proponents point to the enhanced standards and quality assurance mechanisms embedded in existing universal public LTCI schemes. The price and the minimum level of service is set ensuring that individuals with similar LTC needs receive the same level of services across the country (I. Peng, speech, November 18, 2020). Although enhanced standards and quality assurance mechanisms are welcome benefits, particularly in light of the quality issues that have been raised throughout the COVID-19 pandemic, a concern is that addressing these targets at a national level without provincial participation may be a formula for

conflict – as the provinces may perceive such a move as the federal government overstepping the division of powers.

A social insurance approach to funding LTC has been proposed several times in Quebec since 2000 (Adams & Vanin, 2016). Most recently, in 2012, Premier Pauline Marois announced that a task force had been set up to examine the benefits of a loss of autonomy insurance plan (Ibid). The task force 2013 white paper proposed that for the first four years, the loss of autonomy insurance would be funded through the current public funding allocated for LTC plus user fees corresponding to the non-refundable Tax Credit for Home-Support Services (Ibid). In the long term, the proposed option was a capitalized fund, but it was not indicated how it would be funded (Ibid). Consultations were held on the white paper in fall 2013 by the Parliamentary Commission on Health and Social Services (Ibid). In his brief to the Commission, Claude Castonguay, the father of Medicare in Quebec, rejected the idea of a loss of autonomy insurance plan, saying that this would undermine the principle of universality (Ibid). Further, that it was too late to start a capitalized insurance fund because the baby-boom generation was already in the 60s (Ibid). In other words, the plan ought to have started 20 years ago. Despite Castonguay's rejection, Minister Hébert introduced Bill 67, Autonomy Insurance Act, in the National Assembly in 2013 (Ibid). Subsequently, Premier Marois' Government was defeated, Minister Hébert lost his seat and Bill 67 was parked (Ibid).

Alberta also considered the idea of social insurance in the previous decade (Adams & Vanin, 2016). In 2013, Alberta Health and the Canadian Institutes of Health Research co-hosted a "best brains" exchange on policy options for financing LTC (Ibid). This exchange heard presentations on the experiences of the OECD, and Japan in particular (Ibid). The summary report noted agreement that a social insurance model would not be feasible for a single jurisdiction but would need to be implemented on a pooled and pan-Canadian basis (Ibid).

An alternative approach within the literature on LTC cost containment is a targeted system of benefits where the bulk of subsidies for LTC services go to those who lack the means to pay for it (Blomqvist & Busby, 2014). As in the case of the United States, ability to pay is defined to reflect both income and assets (Ibid). Although this system can be effective at limiting costs by targeting funds to low-income individuals, in light of the expected increase in demand for LTC, the adequacy of such a system is

called into question as many individuals in need of care are denied access (Columbo et al. 2011).

In concluding this summary of international models, the English experience over 1999–2014 is instructive for two key reasons. First, it took 15 years and extensive study and consultation to put in place a new funding regime for LTC (Adams & Vanin, 2016). Second, as stated above, although the consultations considered several funding approaches, the decision was made to essentially extend the model already in place (means/assets testing plus general tax revenues) (Ibid). The length of time it took to consider a new funding regime for LTC is sobering from a Canadian perspective, as there has to date been no national policy discussion on financing LTC (Ibid).

Table 6. Select OECD Countries | LTC as a Share of GDP (2019)

OECD Country	LTC as a percentage share of GDP (2019)
Canada	1.9 %
France	1.8 %
Germany	2.1 %
Japan	2.0 %
United States	0.8 %
United Kingdom	1.8 %

Source: stats.oecd.org

Chapter 7. Policy Criteria, Measures and Options

This chapter presents the criteria and measures that are used to evaluate the benefits and drawbacks of the proposed policy options. A total of three policy options are presented and described in detail.

7.1. Policy Criteria and Measures

The criteria for the policy analysis of this study include cost to government, cost to individuals, administrative flexibility, public acceptance, horizontal equity and intergenerational equity. *Table 5* displays a summary of these criteria, along with measures and indices for each.

Table 7. Policy Criteria and Measures

Criteria	Measure	Index
Cost to government	Estimated unfunded cost to government for meeting a politically defined threshold of LTC for all Canadians.	1-High cost to government 2-Moderate cost to government 3-Low cost to government
Cost to individuals	Estimated costs to be borne by LTC recipients and their families.	1-High cost to individuals 2-Moderate cost to individuals 3-Low cost to individuals
Administrative Flexibility	Ability of government to 1) enable the provision of alternate LTC services, and 2) design the means tests and clawback rates associated with public subsidies.	1-High administrative flexibility 2-Moderate administrative flexibility 3-Low administrative flexibility
Public Acceptance (2x)	Acceptability to members of the general public.	1-High acceptance 2-Moderate acceptance 3-Low acceptance
Horizontal Equity	Individuals with similar LTC needs receive the same level of publicly financed services regardless of their income or socio-economic condition.	1-High horizontal equity 2-Moderate horizontal equity 3-Low horizontal equity
Intergenerational Equity	The extent that generations pay equally for publicly financed LTC.	1-High intergenerational equity 2-Moderate low intergenerational equity 3-Low intergenerational equity

7.1.1. Cost to Government

As this study is concerned with the distribution of increased LTC costs between Canadian seniors, their families, and Canadian governments, cost to government is an essential consideration for the evaluation of proposed policy options. Cost to government includes the estimated unfunded cost to government for meeting a politically defined threshold of LTC for all Canadians, using a three-point scale of “high cost to government”, “moderate cost to government”, and “low cost to government”. An added consideration, independent of the proposed policy options, is that currently there is significant differences in the age distribution across the country. As a result, there is likely to be pressure to alter the Canada Health Transfer (CHT) payment program to account for these differences.

7.1.2. Cost to Individuals

For the purpose of this study, cost to individuals includes the estimated costs to be borne by LTC recipients and their families, using a three-point scale of “high cost to individuals”, “moderate cost to individuals”, and “low cost to individuals”. Again, as this study is concerned with the social cost of LTC (the cost to government/public costs and cost to individuals/private costs), the estimated costs to be borne by LTC recipients and their families is an essential consideration for the evaluation of proposed policy options.

7.1.3. Administrative flexibility

Administrative flexibility is another important consideration when proposing options to address health-related policy problems. Administrative flexibility includes the ability of a policy option to enable the provision of alternate LTC services, as well as the level of flexibility in designing means tests and clawback rates of public subsidies. This will be complete using a three-point scale of “high administrative flexibility”, “moderate administrative flexibility”, and “low administrative flexibility”. The inclusion of this criterion is to ensure that Canadians have access to a full continuum of LTC. The promotion of healthy ageing and meeting seniors’ preferences must be accommodated through the provision of a wide range of living arrangements for seniors. As part of this, it is important to determine whether Canadian provinces, in supplying LTC services, are able to envision vouchers or direct supply.

7.1.4. Public Acceptability

The degree to which the general public will support or oppose the proposed policy is considered in this analysis. Public acceptance is measured as the degree to which the public is expected to support the proposed policy, on a 3-point scale of “low acceptance,” “moderate acceptance,” and “high acceptance” with high acceptance scoring higher. An analysis of whether the policies proposed within this study are likely or unlikely to be accepted by the general public has a critical impact on the success of public policy. Not to mention that the representation of public opinion in public policy is of significant importance in representative democracies. Therefore, public acceptance is weighted more heavily than other considerations in the analysis of proposed policy options. Lastly, it is important to note that, inevitably, older generations will be more likely to support some form of national strategy such as a public insurance plan, given that they will receive the benefits having contributed little. Younger Canadians of working-age are more likely to oppose such an option due to the fact that the great majority of Canadian seniors' LTC costs will be placed on general revenue paid by taxpayers of working age.

7.1.5. Horizontal Equity

Horizontal equity is also considered in the analysis of the proposed policies. Horizontal equity can be measured through determining whether, as part of the proposed policy, Canadians with similar LTC needs receive the same level of publicly financed services regardless of their income, socio-economic condition - or payment into the LTC insurance plan. There would be a lack of interprovincial differences in this regard. The proposed policies will be scored using a three-point scale of “high horizontal equity”, “moderate horizontal equity”, and “low horizontal equity”.

7.1.6. Intergenerational Equity

Intergenerational equity is measured by the extent that generations pay equally for publicly financed LTC, using a three-point scale of “high intergenerational equity”, “moderate intergenerational equity”, and “low intergenerational equity”. This is an important consideration as the working-age population in Canada is projected to decline in the next quarter-century and the economic growth rate appears to be falling, meaning

today's working-age generations will likely not have incomes that grow fast enough to offset LTC's rising public costs. Therefore, in other words, this criterion is concerned with the extent to which a given set of fiscal policies for LTC does not shift too large a financial burden on future generations. The goal is to embrace a financing scheme for LTC that includes a set of forward-looking fiscal policies that can help promote a degree of fair sharing of LTC financing within and across generations.

7.2. Policy Options

There are three proposed policies for financing LTC in Canada. They have been selected based on the findings from the literature review and insights gained from the expert interviews. Each has been described below. It should be noted that the pursuit of LTC financing policies must occur while preserving an implicit guarantee of access to a socially acceptable level of LTC, as this is a core value of Canadian social policy. Efforts to make the access guarantee more effective, for example, by reducing waiting lists for institutional/facility-based care or increasing the availability of subsidized homecare for those who need it but do not have the resources to pay for it, should continue to be policy priorities (Blomqvist & Busby, 2014). The development of new policies to finance LTC in Canada should proceed in parallel with these efforts.

7.2.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

The first option is that Canadian governments adopt a universal, mandatory public LTCI plan. While much of the literature on LTC funding in Canada does not examine the specific features that such a plan should have, several studies on public finance and taxation have discussed possible options. These studies have recommended that a Canadian LTCI scheme be open-ended and provide full coverage for LTC services deemed necessary by a multidisciplinary assessment team (Grignon & Bernier, 2012). Two approaches to funding a LTCI scheme in Canada have been proposed. The first is to finance LTCI through employer and employee contributions and the second is through an increase in GST rates.

7.2.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

The second option available for financing LTC is to boost private savings through: a) public education campaigns; b) greater use of existing tax-sheltered savings vehicles; and/or c) the provision of additional tax-sheltered savings specifically for LTC.

Public education

Studies have shown that the majority of Canadians are unaware of the scope of public LTC coverage (Adams & Vanin, 2016). As a result, it has been argued that Canadians are not in a position to make informed decisions as they plan financially for LTC (Ibid). Canadian governments may address this present lack of awareness by informing the Canadian public about the range of LTC services available, as well as the scope of public coverage through public education campaigns.

Greater use of existing tax-sheltered savings vehicles

The Canadian federal government could play a role in providing incentives for Canadians to save for the costs of meeting some of their own LTC needs. One way this could be realized is by allowing existing tax-sheltered saving vehicles to be used for the purpose of saving for LTC. LTC insurance could be treated as a qualifying investment for RRSPs or Registered Retirement Income Funds (RRIF) annuitants. Individuals could withdraw, say, $2,000 tax-free per year (to a maximum of $24,000) from their RRSP/RRIF to purchase LTC insurance (Adams & Vanin, 2016).

Tax-sheltered savings specifically for LTC

The federal government could also explore the possibility of creating an additional tax-sheltered savings vehicle for LTC (Torjman, 2013). A medical savings account (MSA). Canadians would be permitted to contribute a certain amount of money each year to save towards LTC costs. As with the RRSP, tax exemptions could be offered at the front end: the portion of income saved in the MSA would not be taxed, but withdrawals from the account to pay for LTC services would be taxed (Ibid). Alternatively, as with the TFSA, the portion of income saved in an MSA would be taxed, while the income generated by the fund would be exempted (Ibid). In addition, the federal government could make a contribution on behalf of low-income households, as it

currently does for the Canada Learning Bond and Registered Disability Savings Plan (Ibid). A tax-sheltered vehicle for LTC could also take the form of a Registered Education Savings Plan (RESP) (Ibid). Similar to RESPs, contributions by Canadians would be supported by grants from the Government of Canada (Ibid).

7.2.3. Option 3: Mixed | Stricter Means-tested Voucher Scheme

As part of the final option, the provision of means-tested subsidies to preserve access to LTC would remain the guiding principle of provincial policy towards financing LTC. Although this would remain the guiding principle, provincial LTC financing systems would engage in reforms that direct more emphasis on rules that limit government costs and embrace more self-directed LTC (Blomqvist & Busby, 2014). The key elements of this option include: a) limiting subsidy levels; b) revising means-tests through the lowering of clawback rates and the inclusion of assets; c) enabling private LTC insurance to play a more prominent role; d) channelling more subsidies for LTC to patients – in the form of cash or vouchers – rather than directly to the suppliers of services.

Chapter 8. Analysis of Policy Options

As the Canadian population ages, the demand for adequate LTC increases and with it, higher LTC costs. The fundamental objective of the analysis of policy options is to determine the best use of the limited funds available to ensure that adequate LTC is available, at a reasonable cost and appropriate efficiency, to every Canadian who requires it. The underlying principle is a values judgment by Canadians that an adequate threshold of LTC will be available to all. This chapter will analyze each policy option using the criteria and measures outlined in Chapter 7. Scores are summarized in Table 8 at the end of this chapter.

8.1. Cost to Government

8.1.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

A public LTCI program would be ideal in the sense that it would reduce uncertainty for individuals and provide recipients with coverage for a wide range of LTC services. However, it would also be very costly to governments. This is evident in the experience of other jurisdictions that have introduced public LTC insurance. For example, Holland introduced public LTC insurance in 1968, financed by income-based contributions; and Germany created mandatory social LTC insurance in 1995, financed out of general revenues and taxes (Blomqvist & Busby, 2014). While the cost pressures of both of these LTC insurance plans are stressing government budgets in Holland and Germany today, their systems were put in place several decades ago, which means that today's boomer population has been contributing to these costs for several decades (Blomqvist & Busby, 2014). In the Canadian context, boomer payments prior to their entering frail age (over 75) will be much lower than in Holland and Germany. Hence, the public top-up will have to be much greater. Thus, the current anticipated cost to government of adopting this policy option is judged to be high and scored 1 out of a maximum 3.

8.1.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

The second proposed option has been scored 2 out of 3. So long as increased incentives induce higher savings for LTC, the necessary government top up will be smaller than in the case of option 1. However, there exists an opportunity cost to government due to savings incentives. Canadians have shown significant interest in tax-sheltered saving vehicles generally, including the RRSP and the TFSA (Adams & Vanin, 2016). The uptake of the TFSA since it was introduced for the 2009 taxation year has been quite large. According to the Finance Canada's 2012 *Tax Expenditures and Evaluations Report*, as of 2011, there were 8.2 million individuals with a TFSA, representing 31% of tax filers, contributing $30.7 billion that year (Ibid).

In addition, as part of this proposal, the federal government would probably make a contribution on behalf of low-income households, as it currently does for the Canada Learning Bond and Registered Disability Savings Plan (Torjman, 2013). Therefore, overall, the cost to government for this policy option is judged to be moderate.

8.1.3. Option 3: Mixed

The mixed option stipulates that governments fund LTC to assure LTC meets a threshold. Key components of this policy include raising LTC co-payments to a figure closer to the full cost for those with ability to pay and revising means-tests to include assets. The aim of each of these components is to meet a threshold but limit government cost. Cost to government for this option is scored 3; this policy holds the greatest potential to limit government assumption of costs.

8.2. Cost to Individuals

8.2.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

Whether a Canadian LTCI scheme is financed through employer and employee payroll tax contributions or an increase in GST rates, the annual tax increase would presumably be based on an actuarial calculation of revenue required to cover cohorts

over an entire working career. As many boomers are already over 65 and retired, this implies relatively low payments by the boomer cohort. Hence, substantial general revenue would be required to top up. This raises the same problem that occurred for the Canada Pension Plan. Early recipients received CPP pension while having contributed little. As this option would place more of the LTC cost burden onto the government than do the other proposed options, a Canadian LTCI scheme has been scored high 3 out of 3 for cost to individuals.

8.2.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

Most Canadians will not have the necessary savings to take advantage of tax-sheltered LTC savings schemes. A third of Canadian seniors receive the Guaranteed Income Supplement (GIS), which is targeted for those with low incomes (MacDonald et al., 2019). Further, nearly half of Canadian families are nearing retirement without any workplace pension plan and with a mere $3,000 in median retirement savings (Ibid). Therefore, only a minority is likely to take advantage of the subsidy for LTC saving. Adoption of policies to incentivize Canadians to save for their own LTC needs should be a modest supplementary program. The anticipated cost to individuals for this policy option is judged to be moderate and scored 2 out of 3.

8.2.3. Option 3: Mixed

The anticipated cost to individuals for the mixed option is judged to be the highest, hence its score of 1 out of 3. This option is essentially a stricter means-tested voucher scheme – which incorporates family assets in determining the need for public payment. This option puts a greater burden on individuals and families, especially high-income high-asset families.

8.3. Administrative Flexibility

8.3.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

A key component of administrative flexibility in the context of this research is the ability of the proposed policy to enable variation in means to provide LTC services. In Canada, LTC is often criticized on the basis that it lacks a continuum of care (from home and community-based care all the way to institutional/facility-based LTC). LTCI plans in other jurisdictions have expanded the continuum. Germany and Japan serve as examples. Many choose home and community-based LTC services (Peng, speech, November 18, 2020). Not only is this option preferred, home and community-based care are often desirable from a financial and care quality point of view (Ibid). Another key component of flexibility is the ability to change LTCI charges. Once a premium structure is in place, it is politically very hard to adjust it upward. The difficulty associated with increasing CPP premiums in the 1990s serves as an example of this dynamic. By the late 1980s, actuarial analysis implied the need for much higher CPP contributions to sustain the benefit levels. It took almost ten years for Ottawa and the provinces to reach agreement on higher contribution levels. Due to this anticipated rigidity, overall, a public LTCI plan is judged to rank low for administrative flexibility and scored 1 out of 3.

8.3.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

Adjustment of LTCI incentives is politically easier than in the case of Option 1. Nonetheless, it is politically controversial to reduce in-place incentives. Administrative flexibility for this policy option is judged to be moderate and scored 2 out of 3.

8.3.3. Option 3: Mixed

As part of this option, the provinces can channel LTC to patients in the form of cash or vouchers, rather than to the suppliers of services (Blomqvist & Busby, 2016). Therefore, this policy expands the continuum of care by enabling users to choose the optimum means to meets their needs. Further, this policy allows for a means-test that includes both the assets and income of LTC recipients. It is important to note that

introducing an asset test into the formula does raise all of the difficult problems of taxing wealth (e.g., tax avoidance by shifting legal ownership of assets). Government subsidies would be subject to regular adjustments that take into account the scale of LTC needs. The provincial prominence of this policy option is likely to lead to more flexibility than options 1 and 2 which are federal level policy options. National programs typically are more rigid than are provincial programs. Provincial governments are likely to rely on social workers and other professionals to exercise high quality discretion in determining optimal supply of services. Due to the ease of adjustment ideally written into the provincial legislation, paired with the of the ability of this policy to expand the provision of alternate LTC services, administrative flexibility for this option is judged to be high and scored 3 out of 3.

8.4. 8Public Acceptability

8.4.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

The COVID-19 pandemic has had a major impact on how individuals see the country moving forward. In particular, Canadians have shown that they want to see changes made to the way the Canadian LTC system works. A national poll, commissioned by the National Union of Public and General Employees (NUPGE) and conducted by Abacus Data, found that 86 per cent of Canadians are in favour of bringing LTC facilities under the *Canada Health Act (CHA).* Only 2 per cent of Canadians oppose this idea. Further, 78 per cent support increasing funding for LTC. Many proponents of moving LTC under the CHA argue that this move will provide Canadians with the national standards and public accountability that have been lacking for decades. Even before the pandemic, widespread concerns about the sustainability of public LTC and future of unpaid support have led to calls for more integrated funding solutions in which the risks associated with LTC costs are shared among Canadians (Sinha et al., 2019). Based on this survey result, at least in the short turn, Option 1 ranks highest and scored 3 out 3 for public acceptability. That being said, it should be noted that this is a self-serving survey coming from public sector employees. Therefore, given the source, some may doubt the evidence.

8.4.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

Although Canadians have shown interest in tax-sheltered saving vehicles generally, many are not in the financial position to save for LTC. In a 2012 survey, the Canadian Life and Health Insurance Association (CLHIA) found that three-quarters of Canadians admit to having no financial plan in place to pay for LTC (MacDonald et al., 2019). A 2015 national survey conducted by Ipsos Public Affairs for the Canadian Medical Association (CMA) found that 63% of respondents expressed concerns that their families were not in a good position (financially or otherwise) to care for older family members if they needed LTC beyond what is covered publicly (Ipsos Public Affairs, 2015) (Sinha et al., 2019). In its most recent 2019 national survey conducted for the CMA, Ipsos found that that 88% of respondents were worried about the growing health care costs due to the aging population, with 58% reporting that they believed many Canadians will delay their retirement in order to afford the care they will need when retired (Ipsos, 2019). Therefore, it is clear that Canadians are concerned about the public and personal costs of care in older age. This level of concern, as well as the fact that many Canadians lack the ability to save for LTC, explains why public acceptability for this policy option is judged to be low and scored 1 out of 3.

8.4.3. Option 3: Mixed

The experiences of Germany, France, and the Nordic countries have displayed the benefits associated with a voucher-type LTC model. This model enables users to choose the provider that best meets their needs (Colombo, 2011). In many municipalities across the globe, the introduction of greater consumer choice has led to quality improvements (Ibid). Furthermore, revising means tests by including assets is probably popular. This measure would direct more government funding to the majority of Canadians that are unable to accumulate assets to cover the cost of their LTC needs. This offering, along with the global precedence and improved overall public satisfaction associated with this approach, is why public acceptability for this policy option is anticipated to be moderate and scored 2 out of 3.

8.5. Horizontal Equity

8.5.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

LTCI, whether financed through employer and employee contributions or through an increase in GST rates, will probably contain a uniform formula for all in distributing benefits. Therefore, a public LTCI plan ranks highest and is scored 3 out of 3 for horizontal equity.

8.5.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

In terms of horizontal equity and the creation of a new tax sheltered savings vehicle specifically for LTC, the type of vehicle matters. A RESP-type vehicle offers a number of advantages over alternative savings vehicles. Because the government provides grants which help lever the individual's contributions, this plan is attractive for modest income earners for whom any tax deferral benefits are modest relative to those in higher income tax brackets (Torjman, 2013). A policy formulated in this way could enhance horizontal equity. However, whether the government creates a new vehicle or allows for the greater use of existing vehicles, this option is favourable to Canadians that are relatively well-off and can afford to save. Therefore, overall, horizontal equity for this option is judged to be low and scored 1 out of 3.

8.5.3. Option 3: Mixed

Revising means-tests through the lowering of clawback rates and the inclusion of assets; enabling private LTC insurance to play a more prominent role; and channeling more subsidies for LTC to patients – in the form of cash or vouchers – rather than directly to the suppliers of services are key elements of the mixed option. Those with similar income and assets will face the same LTC costs. Further, basing public subsidy on a means-test that includes assets means greater targeting of public subsidy to low-income Canadians needing LTC. Therefore, horizontal equity for the final mixed option is judged to be moderate and scored 2 out of 3.

8.6. Intergenerational Equity

8.6.1. Option 1: Universal, Mandatory Public Long-term Care Insurance (LTCI)

As mentioned above, Holland introduced public LTC insurance in 1968 and Germany created mandatory social LTC insurance in 1995. While the cost pressures of both of these LTC insurance plans are stressing their respective government budgets, the fact that their systems to finance LTC were put in place some time ago means that today's boomer population has been contributing to them for some time. Hence, intergenerational inequity in these countries is less than would be the case with a Canadian LTCI program (Blomqvist & Busby, 2014). The intergenerational inequity from introducing a large public LTCI scheme today in Canada would be severe, because the retiring boomer generation would receive the benefits having paid little. Young cohorts would have to pay enough to cover both the majority of boomers' benefits plus the cost of their own ultimate LTC needs (Ibid). As a result, a Canadian LTCI scheme is scored low 1 of 3 for intergenerational equity.

8.6.2. Option 2: Boost Private Savings | Public Education | Provision of Tax Sheltered Savings Specifically for Long-term Care | Greater use of Existing Vehicles

This option may offer an advantage for younger Canadians given the likely increase in tax rates that will accompany the increase in tax expenditures on healthcare and pensions with the ageing of the baby boom generation. That being said, in general, younger Canadians earn less than those aged 50-65 at peak earning. Hence younger Canadians will take less advantage of the tax-shelter provisions. Further, for the leading edge of the boomers who are already 65 years old, there is little capacity to save. Therefore, a savings vehicle for meeting LTC costs is not well-timed for addressing the needs of the baby boom generation. Because the value of this option largely depends on the age of an individual, as well as the ability of an individual to save towards the cost of LTC, intergenerational equity for this option is judged to be moderate 2 of 3.

8.6.3. Option 3: Mixed

The working-age population share is declining and the economic growth rate appears to be falling, meaning today's working-age generations will likely not have incomes that grow fast enough to offset LTC's rising public costs (Blomqvist & Busby, 2014). This creates a case against new expenditure undertakings that will further redistribute incomes to retirees at the expense of working-age taxpayers over the next several decades (Ibid). For this reason, first consideration should be given to means-test LTC subsidies, which will be lower than the subsidies implicit in options 1 and 2 (Ibid). As limiting subsidy levels and revising means-tests to include assets are key components of the mixed option, intergenerational equity is judged to be high 3 out of 3 for this option.

Table 8. Summary of Policy Evaluation

Criteria	Option 1: LTCI	Option 2: Savings	Option 3: Mixed
Cost to Government /3	High cost to government (1)	Moderate cost to government (2)	Low cost to government (3)
Cost to Individuals /3	Low cost to individual LTC recipients (3)	Moderate cost to individual LTC recipients (2)	High cost to individual LTC recipients (1)
Administrative Flexibility /3	Low administrative flexibility (1)	Moderate administrative Flexibility (2)	High administrative Flexibility (3)
Public Acceptability /3	High public acceptability (3)	Low public acceptability (1)	Moderate public acceptability (2)
Horizontal Equity /3	High horizontal Equity (3)	Low horizontal equity (1)	Moderate horizontal equity (2)
Intergenerational Equity /3	Low intergenerational equity (1)	Moderate intergenerational Equity (2)	High intergenerational Equity (3)
Total/19	12	10	14

Chapter 9. Recommendation & Conclusion

As the Canadian population ages, the demand for adequate LTC increases and with it, higher LTC costs. This project provides a general introduction to a very complicated problem: the distribution of forthcoming increased LTC costs between Canadian seniors, their families, and Canadian governments. In an environment where tax rates are projected to rise because of a declining working-age share of the population and, among other reasons, growing health costs for non-LTC health costs, Canadian policymakers face the challenge of balancing the fiscal burden on taxpayers with the need to ensure that all individuals with LTC needs are guaranteed access to a socially acceptable level of LTC (Blomqvist & Busby, 2012).

Option 1, expanding Canada's public health system to cover the majority of LTC costs should be rejected. On the assumption that the premiums of a LTC insurance plan would be based on a typical working lifetime, the boomer generation will pay only a small share of its LTC costs via premiums. This option will place the great majority of boomer-cohort LTC costs on general revenue paid by taxpayers of working age (Blomqvist & Busby, 2014).

Option 2, boosting private savings through: greater use of existing tax-sheltered savings vehicles; and/or the provision of tax-sheltered savings specifically for LTC, should also be rejected. From the analysis, it is clear that relying on private savings alone is an insufficient and inefficient way to fund LTC given that the vast majority of Canadians are not in a position to save, as well as the type of risk and the uncertainty associated with dependence and the future availability of informal care (Grignon & Bernier, 2012). However, the public education component of Option 2 should be considered as Canadians have displayed a general lack of awareness regarding both the scope of public LTC coverage and the range of LTC services available. Governments may address this present lack of awareness through public education campaigns.

Alongside public education, Option 3, a mixed approach, is recommended. While the Canadian provinces must subsidize LTC for those who lack the means to pay for reasonable care, an alternative targeted approach, under which public subsidies diminish with individuals' ability to pay – defined so as to reflect both income and assets

– holds the greatest potential of putting LTC in Canada on a more sustainable path. Further, this approach would achieve the best balance between the costs to government (i.e., taxpayers) and costs that can be reasonably borne by individuals.

In designing the targeting rules, provinces should find ways to treat assets flexibly for elderly couples when one spouse has high LTC needs and the other spouse remains in the community (Blomqvist & Busby, 2012). Further, so as not to discriminate against middle-income seniors with accumulated savings, the provinces should establish a gradual scale that does not claw back subsidies by one dollar for each additional dollar of private income or assets (Ibid). Private insurance to help pay for LTC costs could be encouraged, especially for seniors who wish to pass on assets, and who might reduce the need for public subsidies to a limited extent (Ibid).

In addition, governments must aim to get good value for the money they spend on LTC and take advantage of opportunities to improve efficiency in the sector. A number of countries that face LTC challenges similar to Canada have been discussed throughout this work. Many of these countries appear to be far ahead of Canadian provinces in addressing these challenges. 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. The preponderance of COVID-19 deaths in LTC-homes has focused attention on the inadequacies of many institutions. The plethora of reviews across the country may lead to much needed improvements to the infrastructure, personnel, regulation, and protocols of LTC institutions. However, the majority of Canadians wish to age in place, in homes and communities they call their own. Canada is an international outlier in spending much more on institutional care of seniors than on home care. Housing options that are flexible and adjustable as needs change with age should begin to be prioritized. Provinces are more likely to accomplish these goals if they channel more subsidies for LTC directly to patients – in the form of vouchers or cash – rather than paying the suppliers of services (Blomqvist & Busby, 2016). This is a key component of Option 3.[2]

Finally, more comparative analysis of the experience across Canadian provinces, as well as in other countries, will be helpful in developing future LTC financing policy.

[2] See Appendix B for a more detailed description of each element of Option 3.

The pandemic has served as a focusing event that has directed public attention towards the sustainability of LTC in Canada. The marginalization of LTC in Canadian policy-making cannot continue. The first wave of baby boomers is already drawing heavily on Canadian LTC programs. It is time to view LTC as a national priority and commit to actively addressing the problems facing this increasingly important sector.

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Appendix A. Jurisdictional Scan | Case Studies

France | Mixed System | Income-related Universal Benefits

Following decades of policy debate, at the beginning of the 21st century, France abandoned the term “long-term care” and created a series of policies that emphasized maintaining the autonomy of the dependent elderly (Blomqvist & Busby, 2016). In order to limit pressure on public finances, the current framework strikes a balance between public and private funding sources (Ibid). In 2000, France introduced the Personal Allowance for Autonomy (APA), which provides public support for dependent elderly aged 60 and above in the form of a monthly cash allowance provided directly to dependents (Ibid). The rationales behind the cash-for-care voucher model were cost containment and increased choice for users (Ibid). In 2019 LTC expenditure in France accounted for 1.8 percent of GDP (*Health Expenditure*, 2020).

The cash benefit is both needs and means-tested (Blomqvist & Busby, 2016). Individuals are assessed for level of disability by a medical and social services team composed of a doctor and social worker (Ibid). Those deemed to require care are classified according to six levels, with the four highest leading to an assistance plan that may include homecare or aid for transportation and meal delivery (Ibid). In 2014, the maximum monthly amounts were approximately 1,300 euros (approximately $2,000) for the highest level of dependency, dropping to 550 euros ($850) for the lowest level (Ibid). Funding for institutional care is based on the costs of 1) accommodation, to be paid by individuals or by social assistance, 2) expenses linked to dependency, which is paid for by the APA and resident co-payments and 3) the cost of healthcare, which is paid for by public health insurance (Ibid). In 2016, over 60 percent of all APA recipients received care in their homes (Ibid). Paid carers can be professional workers or relatives, except for spouses (Ibid). Services are supplied under a quality agreement, which ensures that recipients are seeking out care from qualified workers when looking outside their families for care (Ibid).

The cash allowance is intended to cover only a share of overall costs – individual contributions are expected to pay for the rest (Blomqvist & Busby, 2016). Individuals earning less than $1,050 per month are not expected to contribute financially to their care packages, but co-payments apply for those with incomes above this amount (Ibid).

Those earning more than $4,130 monthly are expected to pay 90 percent of the cost (Ibid). Many French citizens have insured against the need for private co-payments and top-up coverage (Ibid). With over three million policyholders, France has the largest per capita market for private LTC insurance (Colombo, 2011).

Germany | Single Programme | Public LTC Insurance

For most of the post-war era, informal care by family members was the main form of dependent elderly care in Germany (Blomqvist & Busby, 2016). But in 1995, Germany introduced a mandatory insurance scheme for old-age healthcare services (Ibid). As part of this scheme, starting at age 18, workers in Germany made compulsory contributions of 2 percent of payroll income (employers contributed 1 percent) in return for eligibility to receive continuing-care benefits starting at age 65 (Ibid). Germany comprehensively modernised its LTC insurance in the years 2015-2017 by implementing "Long-term Care Strengthening Acts" which triggered an increased LTC insurance spending of more than 5 billion Euro (+ 20%) per year (*Peer Review*, 2017). The new legal regulations increased the level of all existing benefits significantly, in particular those related to homecare (Ibid). New services for support, in particular funding directed towards assistance with activities of everyday life were introduced (Ibid). The contribution rate in the social LTC insurance system was raised 0.5 percentage points, and is now 2.5 percent (2.6 for those without children) of wage income to finance these additional benefits (Ibid). There of 0.1 contribution points filling a public capital stock/ demographic reserve fund as an additional source to finance the expected burden of LTC from the year 2035 onwards (Ibid). The reforms also aimed to use the private LTC insurance market to address the gap between the full cost of care and benefits under the LTC insurance program (Nadash et al., 2018). They did so by subsidizing the purchase of private supplemental LTC insurance policies through the "Pflege-Bahr," a program introduced in 2013 (Ibid). LTC expenditure in Germany accounted for 2.1 percent in 2019 (*Health Expenditure*, 2020).

Seniors eligible for benefits in Germany can receive care either in the form of a cash voucher or through in-kind services with care paths determined by health professionals (Nadash et al., 2018). Every six months, recipients must choose cash, in-kind benefits or a combination of the two (Torjman, 2013). The default option is in-kind, which means that people must actively opt out to receive a cash voucher (Ibid). In

Germany, there are stringent assessment criteria in place to determine care needs. There are three levels: Level I is for those who need minor help with personal care and mobility; the highest level, Level III, means that the recipient requires regular help and assistance and significant nursing help daily (Blomqvist & Busby, 2016). The total benefits vary depending on whether one receives care at home or in an institution, with the intent to encourage more homecare substitution (Ibid). The program currently covers 89 percent of the German population; the remaining 11% are required to purchase private LTC insurance (to supplement their private health insurance) (Nadash et al., 2018). Of the 89 percent, 70 percent received care at home (ibid).

Allowing people in Germany to choose between in-kind care and a cash payment stemmed from concerns that individuals might misuse cash benefits – which is why the level of cash payments is set lower than the costs of providing in-kind services. It pushes individuals toward in-kind care (Blomqvist & Busby, 2012). Since this plan was introduced, more individuals have chosen to receive their care in-kind rather than in cash (Ibid). Cash benefits are given directly to the dependent person, who spends it with oversight by case coordinators and personnel to ensure recipients get sufficient care (Ibid). Cash benefits may be transferred over to informal family caregivers and are not considered taxable (Ibid).

Japan | Single Programme | Public LTC Insurance

In Japan, policymakers have traditionally expected the country's younger generation to care for their aging parents in multi-generational households (Farrell, 2015). Public LTC programs were mostly restricted to low-income elders without family support (Ibid). However, over the past two decades, Japan's family-centered approach has decreased in popularity, due to demographic and economic changes. Daughters and daughters-in-law (the primary caregivers) have become overwhelmed by the task, due to the trend toward fewer children and more women joining the workforce (Ibid). As a result, it became more common for elders to be placed in hospitals (referred to as "social hospitalization") since Japan offered free hospital care to frail elderly – an expensive government policy (Ibid).

Public pressure sparked reform and Japan developed a public, mandatory LTC insurance system in 2000 (Peng, 2020) The program was originally funded half by general tax revenues and half by a combination of payroll taxes and additional insurance

premiums paid by everyone 40+ (Ibid). Currently the program is funded 45% by general tax revenues, 45% by a combination of payroll taxes and insurance premiums and the remaining paid for through co-payments (I. Peng, speech, November 18, 2020). The family remains a key source of caregiving. The system now supports the adult children with subsidized services (adult day care, homecare and nursing visits) (Ibid). Since the introduction of LTC insurance, Japan has steadily reduced its LTC beds in institutions and hospitals and shifted more LTC to homes and communities (Ibid). The number of LTC beds (in both LTC institutions and hospitals) per 1,000 people aged 65+ in Japan is now among the lowest in the OECD, at 33.6, compared with the OECD average of 47.2 (Peng, 2020). In 2019, LTC expenditure in Japan accounted for 2.0 percent of GDP (*Health Expenditure*, 2020).

Seniors in Japan, along with their caregiver, begin the process of seeking benefits by making an appointment at their local community comprehensive care centre (Glauser et al., 2015). There, a case manager, along with a nurse and social worker, assesses the recipients needs through a standardized and lengthy questionnaire (Ibid). Based on this assessment and a report from the individuals doctor, a committee categorizes a recipient into one of seven care levels, each with an associated dollar amount, from around $55 to over $4,300 per month (Ibid). An assessment is repeated every two years or earlier, if care needs rapidly change. Rather than providing cash, the funding can only be used for services (Ibid). The case manager informs the recipient and caregiver about what services are available in their community. Services can range from volunteer-driven community organizations to for-profit nursing homes (Ibid).

United States | Means-tested Safety Net

The United States guarantees access to LTC by offering last-resort public coverage for LTC risks, without specifying a maximum amount of private expenditure (Blomqvist & Busby, 2014). Subsidies offered as part of last-resort public coverage are not paid through the United States Medicare program, the federal social insurance program for individuals aged 65 and up (Ibid). Rather, one can only qualify for LTC benefits through the state Medicaid plans (Ibid). 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 (Ibid). In 2019, LTC expenditure in the United States accounted for 0.8 percent of GDP (*Health Expenditure*, 2020).

A handful of states have modified their Medicaid spend-down rules to make private insurance more attractive to individuals who are trying to protect some of their assets (Ibid). For example, in some states, 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 LTC benefits under their private plans (Ibid). For example, a person whose private plan had paid $100,000 toward the cost of his or her LTC would be allowed to keep $100,000 more in assets than a person without private insurance (Ibid).

A variety of policies have been proposed to make the United States system more affordable and increase access (Blomqvist & Busby, 2014). For example, during the Obama administration the United States federal government attempted to increase the role for government in LTC through the adoption of a government-managed voluntary insurance scheme (Ibid). The Community Living Assistance and Services (CLASS) Act (2010) included provisions for this scheme (Ibid). The plan would have offered LTC 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 homecare or towards the cost of institutional care (Ibid). As a voluntary plan, it would have been possible for employees to opt out (Ibid). The plan was intended as a complement to Medicaid. Due to uncertainty about enrolment, as well as a predicted lack of incentive for individuals to obtain voluntary coverage when a portion of it was available for free through Medicaid support, the administration withdrew the plan in 2011 (Ibid). That being said, the idea behind the CLASS proposal has resonated with policymakers looking to boost private savings via some type of government-managed social insurance plan (Ibid).

On the state government level, in 2019, Washington State committed to implementing a payroll tax beginning in 2022, where employers put 0.58% of a state resident employee's paycheck into a state fund (Sinha et al., 2019). As of 2025, eligible residents will be able to access their new benefit, a $100/day allowance for a variety of LTC services, for up to a year (Ibid). Washington State Gov. Jay Inslee has described this initiative as a "first in the nation" program to provide financial assistance for LTC (Ibid).

United Kingdom | Mixed | Means-tested Safety Net

In the United Kingdom, a mixed system provides LTC through a combination of universal and means-tested long-term care entitlements (Colombo et al., 2011). In 2019, LTC expenditure in the United Kingdom accounted for 1.8 percent of GDP (*Health Expenditure*, 2020). Over the last two decades, there has been much debate about how to finance LTC (Blomqvist & Busby, 2012). The debates began in England in 1999 with the UK Royal Commission on Long-Term Care (Adams & Vanin, 2016). The Commission examined both private and public funding options and concluded that the costs of LTC should be split between living costs, housing costs and personal care (Ibid). Personal care should be available after assessment, according to need and paid for through general taxation (Ibid). The rest should be subject to a co-payment according to means and including assets (Ibid). After this lengthy deliberation, the decision was made to essentially extend the model already in place (Ibid).

Since 1999, England has gone through two rounds of green and white papers on the provision and funding of LTC – which culminated in the passing of the 2014 Care Act (Adams & Vanin, 2016). The first round, conducted in 2005–2006, focussed on making better use of existing public funds through the development of new delivery models with the premise that optimizing available funding could free up resources to improve quality and capacity (Ibid). The next green paper (2009) included a detailed review of five options for paying for care (aside from accommodation costs):

- Pay-for-yourself, through insurance or savings;
- Partnership – a set proportion of basic care and support costs would be paid by the state;
- Insurance – government would work with the insurance industry;
- Comprehensive – all over retirement age would contribute to an insurance scheme (social insurance); and
- Tax Funded.

In the 2010 white paper that followed, the government indicated that it had chosen the comprehensive option "in which everyone makes a fair care contribution" and that it would establish a commission in the next Parliament to determine how to fix the system (Adams & Vanin, 2016). Subsequently, the Commission on Funding of Care and Support, issued a report in 2011. The report recommended a lifetime cap of £35,000

in the contribution individuals would be required to pay for their care costs, subject to means-testing (Ibid). The government acted on the report with the adoption of the Care Act 2014 (Ibid). This Act introduced a lifetime cap on care costs of £72,000, and also increases the threshold on assets for eligibility for state support from £23,250 to £118,000 (Ibid).

Appendix B. Mixed Option | Detailed Description

Including Assets

The level of subsidies for public LTC should be, in part, determined by an individual's assets, not just estimated annual income (Blomqvist & Busby, 2014). Currently, LTC charges are based only on current income in all provinces except Quebec and Newfoundland and Labrador where assets are somewhat taken into account (ibid). Other provinces should consider incorporating asset holdings in their means-testing procedures (Ibid). This could be done in ways that would protect surviving spouses and not force seniors to sell assets prematurely. For example, collection of some charges could be postponed until after the patient's death, or the death of a surviving spouses (Ibid). While seniors with children or grandchildren may want to preserve their assets in order to pass them on, some argue that this should be a consideration in assessing the degree to which taxpayers should subsidize their LTC (Ibid).

Limiting Subsidy Levels

Private fees across Canada are set to cover only the hotel and lodging costs associated with LTC (Blomqvist & Busby, 2014). Yet, there is a large amount of variation from one province to another (Ibid). In the provinces that impose the highest patient charges on well-off patients (BC and Nova Scotia), monthly charges were only a little over $3,000 in 2011, or about $36,000 per year (Ibid) In Ontario and Alberta, the monthly charges were about $1,400, or about $17,000 annually (Ibid). One way in which LTC costs could be limited would be to raise these charges/ co-payments to a figure closer to the full cost for those with a high ability to pay.

Revising Means-tests

In several provinces where the ability to pay is defined on the basis of a patient's income, the amounts that patients within LTC facilities have to contribute toward the cost of their own care rises by one dollar for each additional dollar of income that they declare, up to a maximum (Blomqvist & Busby, 2016). These provinces should consider including assets and lowering clawback rates, as high rates reduce an individual's incentive to save for future needs. Saskatchewan serves as an example. In

Saskatchewan the clawback rate is 50 percent, meaning that the subsidy is reduced by 50 cents for each dollar increase in a patient's declared income and assets, down to a specified minimum (Ibid).

Private LTC Insurance | Tax Credit or Subsidy

Canadian governments might encourage more effective financial-risk pooling through policies that enable private LTC insurance to play a more prominent role than it currently does (Blomqvist & Busby, 2016). Risk pooling through voluntary private health insurance is subject to well-known problems (Ibid). Mainly, the crowding-out phenomenon whereby the existence of an access guarantee effectively acts as an implicit public insurance plan that "crowds out" private LTC insurance to a significant extent (Ibid). However, there are ways in which this could be overcome. For example, In the UK, where the income tax system includes similar tax deferral and exemption provisions, the British Bankers' Association – in a brief to a royal commission on LTC – suggested that taxation of the proceeds from retirement income funds could be further liberalized to provide added incentive for individuals to sign up for private LTC insurance (Blomqvist & Busby, 2014). Specifically, it proposed that, while remaining tax-free, a lump-sum pension transfer could be taken upon retirement (up to 25 percent of the total pension) and be used for the purchase of LTC insurance (Ibid). Rules of this kind should be considered in Canada.

Self-directed Care

Following the example of some European and Nordic countries, provinces could channel more subsidies for LTC to patients – in the form of cash or vouchers – rather than directly to the suppliers of services (Blomqvist & Busby, 2016). As part of the transition to a voucher-type model, in assessing patients for LTC needs, administrators should consider their activities of daily living (ADL's) and limitations (their need for care) (Blomqvist & Busby, 2012). Further, patients eligible for nursing home placement or homecare 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) that they can use in the private market (Ibid). 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 (Ibid). There are many benefits associated with a voucher-type model. For example, this model enables users to choose the

provider that best meets their needs (Colombo, 2011). In many municipalities across the globe, the introduction of greater consumer choice has led to quality improvements and forced them to seek options for containing the cost of their service production (Ibid). That being said, a well-designed voucher system would need to overcome some challenges. Firstly, one potential weakness of a voucher system – one shared with the current system of LTC found in most provinces – is that the size of the voucher, or public subsidy, needs to change over time with a patient's needs (Blomqvist & Busby, 2012). The number of chronic conditions suffered by individuals in LTC tends to grow over time – after a patient has been admitted to a residential care facility his or her needs might increase dramatically (Ibid). Without regular adjustments to the level of subsidies, LTC facilities may have to discharge more patients to hospitals if care needs become too burdensome (Ibid). Therefore, a well-designed voucher program should take into account the scale of LTC needs and periodically revise the size of the voucher accordingly (Ibid).