



**HOME CARE, AND CARING FOR PERSONS SUFFERING
FROM A LONG-TERM LOSS OF INDEPENDENCE:
A FUNDING MODEL FOR CANADA**

**Philippe Le Goff
Economics Division**

6 January 2003

**PARLIAMENTARY RESEARCH BRANCH
DIRECTION DE LA RECHERCHE PARLEMENTAIRE**

The Parliamentary Research Branch of the Library of Parliament works exclusively for Parliament, conducting research and providing information for Committees and Members of the Senate and the House of Commons. This service is extended without partisan bias in such forms as Reports, Background Papers and Issue Reviews. Analysts in the Branch are also available for personal consultation in their respective fields of expertise.

**CE DOCUMENT EST AUSSI
PUBLIÉ EN FRANÇAIS**

TABLE OF CONTENTS

	Page
SUMMARY	i
INTRODUCTION.....	1
THE HOME CARE SECTOR IN CANADA: CURRENT AND FUTURE CHALLENGES.....	3
A. The Aging Population	3
B. Pressure on Informal Caregivers	4
C. Human Resources	4
D. Service Charges and Rationing	4
LOSS OF INDEPENDENCE IN INDUSTRIALIZED COUNTRIES: THE MAJOR CARE MODELS	5
A. Tax Funding Model.....	5
1. Overview	5
2. Advantages.....	6
3. Disadvantages.....	6
B. Social Insurance Model	7
1. Overview	7
2. Advantages.....	7
3. Disadvantages.....	8
4. Example: The German Long-term Care Insurance Model.....	8
C. Mixed Model	10
1. Example: The French Model.....	10
VOLUNTARY PRIVATE INSURANCE	13
A. Barriers to Development of Voluntary Private Insurance for Long-term Care.....	14
B. Private Insurers' Difficulty in Estimating Probability of Seriousness and Cost of Dependence	16
A MODEL FOR CANADA.....	17
APPENDIX	

SUMMARY

This paper examines the challenges Canada will have to face in caring for individuals suffering from a loss of independence, and suggests that the reforms recently proposed in this area, although valid, constitute only partial responses to Canadians' present and future needs. Profiting by the experience of countries that have already taken measures to address the consequences of the aging of their populations and that have implemented complex and varied systems for caring for dependents, Canada now has an opportunity to develop a genuine policy on aging consistent with its needs and values in order to achieve its objectives in this area. The following paper suggests the creation of a social insurance fund integrated into the Canada Pension Plan and Quebec Pension Plan and featuring characteristics of the German and French models.



CANADA

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

HOME CARE, AND CARING FOR PERSONS SUFFERING FROM A LONG-TERM LOSS OF INDEPENDENCE: A FUNDING MODEL FOR CANADA

INTRODUCTION

As more and more Canadians prepare for retirement, it is very probable that access to long-term health care (LTC) and funding for that care will become one of their major concerns. In Canada, as in most industrialized countries, home care will likely be a preferred method for providing care to persons who are losing their independence,⁽¹⁾ or suffering from temporary disabilities or chronic diseases that result in some form of dependence.

Each province and territory currently offers a home care program. However, as home care is not considered a medically necessary service under the *Canada Health Act*, public home care services vary enormously across the country with respect to their organization, the care and services provided and the user fees charged. In addition, it is generally agreed that there are many gaps in home care coverage and that the sector is underfunded and underdeveloped relative to the needs of its clientele.

In October 2002, the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee) tabled its final report on Canada's health care system.⁽²⁾ The report included three major recommendations for reinforcing home care in Canada. The first concerned post-acute home care (post-hospital home care):

[That] [t]he [post-acute home care] program be treated as an extension of medically necessary coverage already provided under the *Canada Health Act*, and that therefore the full cost of the program should be borne by government.⁽³⁾

-
- (1) The expressions "dependence" and "loss of independence" are used interchangeably in this paper.
 - (2) Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role – Final Report on the State of the Health Care System in Canada*, Ottawa, October 2002, chap. 8 and 9 [hereinafter Kirby Committee (2002)].
 - (3) *Ibid.*, p. 159.

The second and third concerned palliative home care:

[That] [t]he federal government examine the feasibility of allowing Employment Insurance benefits to be provided for a period of six weeks to employed Canadians who choose to take leave to provide palliative care services to a dying relative at home.⁽⁴⁾

[That] [t]he federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.⁽⁵⁾

According to the Senate Committee's estimates, post-acute home care would cost \$1.1 billion a year (funded equally by the federal government and the provinces), and the payment of Employment Insurance benefits to workers who take temporary leave to provide palliative care to a family member would cost approximately \$250 million a year. These measures would undoubtedly be very helpful to care recipients and informal caregivers and would offset a portion of the costs borne by all economic agents. Similar programs, moreover, already exist in certain countries such as Sweden⁽⁶⁾ and Germany.⁽⁷⁾

Given the costs involved, the Senate Committee's choice of post-acute and palliative home care as the first step in expanding health care coverage under the *Canada Health Act* was no doubt deliberate. However, even if the Senate Committee's recommendations were one day to become reality, they would affect only about one-third of the volume of home care. Approximately two-thirds of home care is provided to persons requiring long-term care.⁽⁸⁾

The Commission on the Future of Health Care in Canada (Romanow Commission) has proposed that a new Home Care Transfer (\$980 million a year) be created to establish a national home care program, and that the *Canada Health Act* be revised to include home care services coverage in what are deemed to be priority sectors. The Commission suggested focussing on care for persons suffering from mental illness and those requiring palliative or post-hospital care (including drugs and rehabilitation services). Provincial and

(4) *Ibid.*, p. 166.

(5) *Ibid.*

(6) M.-E. Joël, "Note sur la protection sociale en Suède," in *La dépendance des personnes âgées : Synthèses et perspectives*, report of the task force chaired by J.-P. Delalande and M.-T. Join-Lambert, Haut Conseil de la Population et de la Famille, Paris, 1999.

(7) Rudolf J. Vollmer, "Long-Term Care Insurance in Germany," address presented at the European Seminar on Dependency, Porto, 12 May 2000.

(8) Health Canada, *Provincial and Territorial Home Care Programs: A Synthesis for Canada*, June 1999.

territorial resources currently allocated to home care in the above sectors could thus be freed up and redeployed to enhance services offered to persons suffering from a physical disability or chronic illness.⁽⁹⁾ Like the Kirby Committee, the Romanow Commission recommended that informal caregivers be assisted through the Employment Insurance program.

It is very likely, however, that the new resources recommended by these two working groups for the home care system would soon become inadequate. The forecast scarcity of informal caregivers and the aging of the population (see Appendix) will put growing pressure on the available public resources, and it will sooner or later be necessary to reexamine Canada's approach to funding and organizing home care and LTC in general.

This paper focuses on the various options for funding the care of persons who have lost their independence, and for funding long-term home care that can guarantee Canadians adequate access to necessary care and services. The first section provides an overview of the future challenges and current weaknesses in the home care sector in Canada. The second looks at major models elsewhere for funding the care of dependent persons, and assesses the economic advantages and disadvantages of each. The third concerns voluntary private insurance and barriers to its development. The last section examines the best options for responding to Canada's needs.

THE HOME CARE SECTOR IN CANADA: CURRENT AND FUTURE CHALLENGES⁽¹⁰⁾

A. The Aging Population

Meeting LTC needs, in particular home care for dependent persons,⁽¹¹⁾ is an enormous challenge for the Canadian health system, and one that will grow with the aging of the "baby boomers" in the coming years.

Although people can lose their independence at any time, that loss becomes more frequent with age, particularly after the age of 80.⁽¹²⁾ Based on Statistics Canada's latest

(9) Commission on the Future of Health Care in Canada, *Final Report*, Ottawa, November 2002, p. 179.

(10) See P. Le Goff, *Economic Problems of the Home Care Sector in Canada* (PRB 02-29E), Parliamentary Research Branch, Library of Parliament, October 2002.

(11) A person is considered "dependent" when he or she needs significant assistance in performing "essential acts of living" such as those required for personal hygiene, eating, moving around and housekeeping, on a permanent basis, that is to say, in all likelihood, for at least six months.

(12) Laurence Assous and Ronan Mahieu, *Le rôle de l'assurance privée dans la prise en charge de la dépendance : une perspective internationale*, France's Ministère de l'Emploi et de la Solidarité, November 2001.

demographic projections, one person in five will be 65 years of age or more in 2026, compared to approximately one in eight in 2000.⁽¹³⁾ The fastest-growing age group will be that of persons 80 and over, rising from 920,000 in 2000 to 1.9 million in 2026, an increase of more than 100%.

B. Pressure on Informal Caregivers

Most home care (75 to 90%) today is provided – usually without pay – by families, most often by women.⁽¹⁴⁾ However, declining birth rates, the increased participation of women in the workforce, rising divorce rates, the increase in the number of single-parent families and the geographical dispersion of families are factors that limit, and will continue to limit, the ability of families to take on greater home care responsibilities.

C. Human Resources

In its annual report on home care in Canada, Canada's Association for the Fifty-Plus identified human resources as the major issue in the home care sector.⁽¹⁵⁾ Inadequate pay, mediocre working conditions and major staff recruitment and retention problems appear typical of the home care sector in Canada. Given that human relations are crucially important in this sector, this situation deserves further attention, in view of its potential impact on the quality of services provided to a vulnerable clientele.

D. Service Charges and Rationing

All provinces currently impose quotas on the amount of health care a beneficiary may receive, and the waiting lists for certain services are growing longer.⁽¹⁶⁾ Most provinces also charge user fees in proportion to clients' incomes. Lastly, a number of providers rely on the use of private sector services by more well-to-do patients in order to meet the demand, which exceeds the resources available in the public system. Overall, these measures are tantamount to

(13) Statistics Canada's demographic projections for 2000-2026, *The Daily*, 13 March 2001 (<http://www.statcan.ca/Daily/English/010313/td010313.htm>).

(14) Canadian Home Care Human Resources Study, *Setting the Stage: What Shapes the Home Care Labour Market?* Phase 1 Highlights, 4 December 2001 (<http://www.homecarestudy.ca/en/news/docs/highlights-final.pdf>).

(15) Karen Parent *et al.*, "Home Care by Default, Not by Design," *CARP's Report Card on Home Care in Canada 2001*, p. 6.

(16) Health Canada (1999).

transferring a portion of the cost of health care and part of the burden for delivering that care to beneficiaries, families and other unpaid informal caregivers.

LOSS OF INDEPENDENCE IN INDUSTRIALIZED COUNTRIES: THE MAJOR CARE MODELS

Institutional systems for providing care to dependent persons in industrialized countries may be divided into three major groups on the basis of organization and funding.

Tax funding model⁽¹⁷⁾ – Under this model, dependent persons are largely cared for by the community. Canada, the United Kingdom and the Scandinavian countries are in this group.

Social insurance model⁽¹⁸⁾ – In the German-speaking countries, the Netherlands and Japan, dependence has been recognized as a new “social risk” and care for dependent persons is provided through social insurance plans funded through designated contributions.

Mixed model – In the majority of countries, elements of the first two models have been combined in a “mixed” model. France, which has just reformed its system for the care of persons who have lost their independence, is a good example.

A. Tax Funding Model

1. Overview

The tax funding model is a universal social security system that is independent of personal means. In theory, the organization and funding of LTC in Canada are typical of this model. Provincial LTC models are currently funded out of each province’s public treasury, which is in turn funded through tax revenues and federal transfers. Federal government transfers

(17) The tax (or general taxation) funding model is also called the “Beveridge model,” after Lord Beveridge, a British economist and administrator who worked in the field in the mid-20th century. The system is essentially funded through taxes and placed under government authority. The taxes in question are both direct and indirect. Direct taxes, to which individuals, corporations and property are subject, include, in particular, taxes on income, capital, profits and property. Indirect taxes apply to transactions, goods and services (sales tax, excise tax, etc.). Each form of taxation has a specific impact in terms of equity and efficiency. Direct taxes are usually progressive, and indirect taxes regressive. The equity of a tax system thus depends on its structure – the number and level of marginal income tax rates and the percentage of tax revenues from indirect taxes.

(18) The social insurance model is also called the “Bismarck model,” named after the German chancellor who, in the late 19th century, created the first social insurance system, funded through employer and employee contributions and placed under government authority.

to the provinces make it possible to ensure that a certain degree of standardized care is provided to the public, despite the varying levels of tax resources across the provinces. In Sweden, by comparison, responsibility for the organization and delivery of LTC has been devolved to the municipalities, which fund their services through municipal taxes and transfers from the Swedish government.⁽¹⁹⁾

In practice, however, the increased demand for LTC tends to guide the tax funding systems of many countries – including Canada – toward a social welfare arrangement. Depending on the administration, the level of service is subject to means tests or rationed by means of quotas, user fees or waiting lists. Priority is given to those in the greatest need. The problem of accessibility inevitably arises and becomes a crucial issue, which undermines the principle of universality underlying this model. All countries are thus proposing reforms and examining the advantages and disadvantages of this funding method.

2. Advantages⁽²⁰⁾

Studies on health economy acknowledge that funding health care through taxes has certain benefits:

- In terms of efficiency, fewer distortions are introduced into the economy because all economic players are involved.
- Administrative costs are generally low.
- Funding permits better control of costs.
- The impact on labour costs and mobility – and thus on the economy – is limited.

3. Disadvantages

Tax funding also entails certain disadvantages:

- Funding depends not only on clients' needs, but also on political factors.
- Funding is less transparent and often competes with other government priorities.

(19) Swedish Department of Health and Social Affairs, *Policy for the Elderly*, Fact Sheet, Stockholm, March 2001.

(20) Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin, *Funding Health Care: Options for Europe*, European Observatory on Health Care Systems Series, Buckingham (U.K.), 2002, pp. 272-300.

- The amount of resources allocated to health care varies according to economic circumstances and government tax revenues.
- There is little correlation between the level of taxation and services received.

These disadvantages have led some to propose that a specific tax be instituted to fund health care. The terms and conditions of the tax could mitigate these disadvantages.⁽²¹⁾

B. Social Insurance Model

1. Overview

Although some variations have developed in the different countries that have adopted it, the social insurance model has two basic features. First, insured parties pay regular contributions based on salary, similar to Canada's Employment Insurance program. Second, an independent public or para-public organization (commonly called a fund) collects and manages the insureds' contributions and pays the required benefits to health service providers or directly to the insureds. The model generally includes the following components:

- Contributions are mandatory for most of the population.
- Contribution levels are generally not related to the risk presented by the insured.
- Contributions may be shared by the employer and employee.
- National systems may have one or more funds. Each fund may be linked to a specific geographical area, category of worker, etc.; or individuals may join the fund of their choice.
- In countries where there is more than one fund (in competition or not), mechanisms must be developed to share risk.
- The government pays the contributions of persons who are unemployed or out of the workforce.

2. Advantages

Since there are a number of social insurance models, they do not all offer the same advantages. However, studies confirm that this type of organization and funding offers the following advantages over tax funding:

(21) Kirby Committee (2002), pp. 275-278.

- It provides greater protection against political factors.
- It reacts more effectively to clients' needs.
- It is more transparent for insured parties, who can see the direct link between contributions paid and services received.
- Funding is more stable.
- With the exception of consumption taxes, the social contribution is the type of fiscal contribution that has the least impact on economic production as a whole.⁽²²⁾

3. Disadvantages

The disadvantages of the social insurance model are as follows:

- Companies' contributions increase labour costs, and can undermine employment and corporate competitiveness.
- Since only employers and employees contribute, tax transfers are needed to fund coverage for those not in the workforce (unemployed, retired);
- Tax transfers from the central government to the fund(s) may be needed to offset fund deficits or, in systems involving a number of funds, to offset income/expense disparities between funds.
- In most forms of this system, employee contributions are proportionate to income and subject to a ceiling; the model tends, therefore, to be regressive.
- In countries where there are a number of funds, differences in membership criteria and in the benefits provided, and potential constraints on the portability of coverage from one fund to another, can impede labour mobility and be economically inefficient.
- Although there is, in theory, less cost control in a social insurance context (since funds can adjust contribution rates to reflect their expenses), that prerogative can be limited by the government.

4. Example: The German Long-term Care Insurance Model

In Germany, the law on long-term care insurance, which has been in effect since 1995, guarantees all beneficiaries of the public health insurance system specific coverage for LTC, including home care.⁽²³⁾ Persons registered in the public health insurance system

(22) *Ibid.*, p. 280.

(23) Assous and Mahieu (2001).

automatically receive long-term care insurance coverage (approximately 90% of the population). Persons who voluntarily take out private health insurance (approximately 10% of the population) may ask to be exempted from the public insurance system if they can prove that they are covered by equivalent private insurance. This coexistence of public and private insurance systems is similar, in some respects, to the drug insurance situation in Quebec. Private long-term care insurance in Germany is highly regulated and must provide benefits at least equivalent to those of the public insurance system.

The benefits provided by Germany's long-term care insurance system cover the following areas:

- home care;
- respite services for informal caregivers;
- part-time helpers and part-time care;
- stays at short-term care centres;
- technical aids (specialized equipment and material, housing adaptation assistance);
- training for informal caregivers;
- social security benefits for informal caregivers;
- institutional care.

The first seven types of benefits are designed to encourage home care rather than institutional care.

In 2001, nearly 1.9 million persons received benefits from the public long-term care insurance system and 100,000 persons received private plan benefits.⁽²⁴⁾ Nearly 78% of beneficiaries were 65 years or over, while 5% were under 20. Benefits do not vary with income and depend only on need. Approximately 30% of dependent persons receive institutional care. The vast majority of beneficiaries (70%) thus receive home care benefits. They may choose to receive either direct benefits – that is, services from professionals under contract with the public insurance system – or cash benefits which they may use as they wish to compensate an informal caregiver. A combination of the two is also possible, but direct benefits are worth nearly twice

(24) These figures are taken from the Web site of the German Federal Department of Health (in German only).

as much as cash benefits. On average, three-quarters of beneficiaries (non-institutionalized) opt for cash benefits.

In Germany, long-term care insurance is funded through a contribution of 1.7% of gross salary, shared equally by employers and employees. The German parliament sets the contribution rates. In 1995, when the system was introduced, employers were compensated for that additional contribution by the elimination of one paid day of leave. Retirees cost-share premiums equally with their pension fund.

While the mechanism guarantees universal access to long-term care insurance, it does not cover all costs incurred as a result of dependence. In particular, housing costs are not covered. Private insurers profit by this situation to encourage insured parties to take out additional coverage. As a result, a large market has developed for supplementary insurance against dependence – daily allowances, reimbursement of expenses or a combination of the two.

C. Mixed Model

The mixed model – in all its forms – has resulted from the reforms introduced in certain countries to correct problems with the funding or organizing of their LTC system, or to improve it in light of experiments conducted in other countries or in other fields of social security.

The mixed model combines the use of taxes and payroll contributions. This helps to stabilize the resources allocated to LTC throughout the economic cycle, to reduce the amount of political intervention and the impact on labour costs, and to make a closer link between contributions paid and services received, as is the case in Belgium and France.

1. Example: The French Model

In France, long-term home and institutional care is provided to the public through two systems that are governed by specific access rules and separate funding methods, but which have generally proved essential in providing high-quality care:

- assistance with everyday needs⁽²⁵⁾ is provided through the *allocation personnalisée d'autonomie* (APA) [Personalized Independence Allowance],⁽²⁶⁾ which is paid, on certain conditions, to elderly persons who have lost their independence;

(25) Washing, dressing, walking, eating, etc.

(26) Most of the information on the APA is taken from the *Guide Pratique de l'Allocation personnalisée d'autonomie* [Personalized Independence Allowance Handbook] published on-line by the French Ministère de l'Emploi et de la Solidarité, updated in December 2001.

- home and institutional medical care is provided by the public front-line paramedic system (nursing care, rehabilitation) and funded through *health insurance*.

Health insurance is a branch of Public Social Security, which is responsible for protecting citizens from the financial risks entailed by sickness. Mutual and private insurance organizations provide additional protection. Health insurance is funded through both taxes and payroll contributions.

The APA, which is the keystone of the vast French mechanism for providing care to elderly persons who have lost their independence, came into effect on 1 January 2002, replacing the specific dependence benefit. The APA is designed to provide better care for the elderly who have lost their independence; it helps them to meet their everyday needs and to cover, in whole or in part, the costs entailed by physical or mental dependence.

In the case of persons living at home, for example, the allowance can be used to pay employees, an accredited home help service or a third party authorized to take the beneficiary into his or her home in exchange for payment; it can also be used to pay certain dependence-related expenses. It is generally paid directly to the beneficiary, who pays a third party (excluding a spouse). If the beneficiary is dealing with a recognized private organization, the amount may be paid directly to that organization, with the beneficiary's consent. The APA is based on the following five guiding principles.

- *An objective and universal right* – The APA is intended for all elderly persons (60 years and over) who have lost their independence and require public support. It is standardized across the country; the amount of the allowance is determined by a national tariff based on the degree of dependence. A national scale is also used to determine, on the basis of the user's means, how much the user will pay.
- *Accessibility* – The APA is not conditional upon passing a personal means test that would eliminate higher-income applicants. It may be granted to any person who has a medium or high degree of dependence.
- *Flexibility* – The APA may be allocated to meet the specific needs of each person. In addition to paying for the services of home care providers, it may be used for a range of other services such as housekeeping help, day care, temporary assistance, technical aids and housing adaptation.
- *Support for modernizing home care* – The APA was implemented together with a Home Assistance Modernization Fund, which provides support for training, the professionalization of home care services, and innovations and improvement in service quality.

- *Front-line management* – The financial component of the APA is managed by France's départements (sub-regional governments), while the Communal Social Action Centres within each département generally coordinate assistance and support services for elderly persons.

Funding for the APA is provided through the APA Fund established by the French government. Its operation is governed by a board of trustees, a board of directors and an executive. Fund revenues come from two sources:

- a portion of proceeds from the General Social Contribution (0.1%);⁽²⁷⁾ in 2002, that contribution was expected to represent approximately 762 million euros (C\$1.165 billion); and
- a contribution paid by all mandatory old age insurance plans, amounting to 76 million euros in 2002 (approximately C\$116 million).

Most of those revenues are handed over to the départements to help finance the costs of paying the APA to citizens. The remainder is used to finance the modernization of home services for elderly persons through the Home Assistance Modernization Fund.

The level of allowance to which the beneficiary is entitled is determined through a professional assessment by a physician and a social worker. Aspects of the potential beneficiary's material, social and family environment are all considered.

The amount of the APA that each beneficiary receives is equal to the amount of the assistance plan established for the beneficiary, less an amount to be paid by the beneficiary, based on his or her financial resources. In 2002, if the applicant's monthly income was less than 914 € (approximately C\$1,400), he or she would receive the maximum allowance established on the basis of the professional assessment of his or her needs. If the applicant's monthly income was between 914 and 3,100 € (between C\$1,400 and 4,750), that person's contribution would gradually increase from zero to 80% of the amount of the assistance plan. For incomes greater than 3,100 €, the APA received by the beneficiary was equal to 20% of the amount of the assistance plan.

Where a beneficiary lives with a spouse, the latter's resources are also considered, as is capital property, except for the beneficiary's principal residence.

(27) The General Social Contribution is the main revenue source of the Old Age Solidarity Fund, France's equivalent of the Canada Pension Plan and the Quebec Pension Plan.

Amounts paid in respect of the APA are not taxable. Furthermore, an APA home care beneficiary who pays one or more employees or receives benefits from a recognized organization may deduct 50% of expenses borne and not covered by the APA for income tax purposes, to a maximum amount of 6,860 € (approximately C\$10,500).

VOLUNTARY PRIVATE INSURANCE

Today, in virtually all industrialized countries, voluntary private insurance (VPI) coexists with public systems in the care of persons suffering from loss of independence. It plays a part in funding long-term home and institutional care.

Studies of the health insurance field identify three types of voluntary private insurance:⁽²⁸⁾

- substitutes for mandatory public systems;⁽²⁹⁾
- complementary coverage for services partly covered or not covered by the public system;
- supplementary coverage providing faster access to care, while providing consumers with more choice.

In practice, products offered by insurance companies often provide complementary or supplementary coverage.

During the 1980s and 1990s, the complementary private insurance market for health care in general (including LTC) developed quickly in the countries of the European Union where public health services adopted user fees (Belgium, Denmark, France, Ireland and Luxembourg). The supplementary private insurance market, on the other hand, developed more quickly in countries where access to certain types of care (such as surgery) provided by the public system is characterized by long waiting lists (United Kingdom, Greece).⁽³⁰⁾

(28) Mossialos *et al.* (2002), p. 129.

(29) For example, in Germany, the Netherlands and Spain, certain segments of society are not covered by the mandatory public system or may, under certain conditions, be exempted from it and opt to take out private insurance. Depending on the country, high-income earners, self-employed workers and government employees are target clienteles for substitute private insurance.

(30) Mossialos *et al.* (2002), p. 131.

In Canada, the public LTC system has both of the disadvantages seen in Europe: user fees, which depend on available resources; and waiting lists for certain services. The European experience of the past two decades suggests that the demand for voluntary insurance products in Canada will increase. That appears to be the view of the insurance industry, which is familiar with demographic projections and deficiencies in the public LTC system and is therefore attempting to sensitize the public to the dependence phenomenon and thus to the importance of LTC insurance.

According to a survey conducted in July 2002 for RBC Insurance,⁽³¹⁾ 12% of Canadians have VPI for LTC. Compared to data available for certain other countries, that percentage is surprisingly high.⁽³²⁾ However, it is possible that some of those questioned who answered in the affirmative confused LTC insurance with group long-term disability insurance (8.3 million insureds in 2000),⁽³³⁾ to which employees subscribe through their employer. Most long-term disability insurance, however, is not transferable from one job to another and ceases when the employee retires, whereas people generally begin to lose their independence from that point on.

According to the same survey, 47% of Canadians are concerned about losing their independence and about the prospect of becoming a burden to their families. Yet only 49% of respondents said they had heard about VPI for LTC, which shows the extent to which the public misunderstands and underestimates the risk and cost of dependence. Canadians are not alone in this, which explains in part why VPI for LTC is slow in developing around the world.

A. Barriers to Development of Voluntary Private Insurance for Long-term Care

In theory, VPI offers certain benefits as a way of funding health care.⁽³⁴⁾

(31) Ipsos-Reid survey on long-term health insurance; the results were published on 10 July 2002 (<http://www.ipsos-reid.com/english/index.cfm#>).

(32) According to the Health Insurance Association of America, the number of persons who took out long-term health care insurance reached 6.8 million by the end of 1999 (2.5 % of the population). In France, 940,000 persons (1.5 % of the population) had a private dependence insurance contract by the end of that year (Fédération française des sociétés d'assurance). In the United Kingdom, the number of dependence insurance policies in effect at the end of 2000 was only 34,000 (0.05 % of the population) (Royal Commission on Long-Term Care).

(33) Canadian Life and Health Insurance Association Inc., *Canadian Life and Health Insurance Facts 2001*, p. 13.

(34) Mossialos *et al.* (2002), pp. 110-111.

- it offers greater potential for innovation and efficiency as a result of its flexibility and profit incentives;
- it encourages individuals to provide for their future;
- it gives the consumer more choice;
- it has the potential to free up public resources.

Both in theory and in practice, however, VPI has a number of disadvantages that limit its large-scale introduction. On top of the problems typically associated with private health care insurance, VPI for LTC faces specific problems because dependence is a “chronic”⁽³⁵⁾ intertemporal risk (see below) that occurs in a changing demographic, economic and health environment. The following three factors on the demand side help to explain the modest growth of private insurance for LTC.

- *Low level of interest and priority given to the risk of dependence* – As noted above, most people, particularly young people, do not consider it a priority to insure themselves against a risk with unknown costs or timing (it may occur in 30, 40 or 50 years), at a time when they have to address more immediate financial priorities.
- *High cost of premiums* – Although seniors’ financial situation has vastly improved in recent decades, only a minority can likely take out high-quality VPI for LTC without appreciably compromising their quality of life. One study has found that, in the best of cases, 30% of the population would be able to insure themselves in the United States.⁽³⁶⁾ However, the American VPI for LTC market is one of the most developed and most competitive in all the industrialized countries.
- *Unfamiliarity with public system coverage* – In general, people are not fully aware of the coverage offered by the public LTC system (including home care); as a result, they cannot accurately assess their present or future needs for complementary or supplementary LTC coverage.

Among the insurers, the main question is whether the risk of dependence is insurable, particularly as a result of the uncertainties surrounding the cost of long-term health care. The main factors to consider are the following.

(35) Laurence Assous and Pierre Ralle, “La prise en charge de la dépendance des personnes âgées : une mise en perspective internationale,” International Conference on Social Security Research, Helsinki, September 2000, p. 15.

(36) J. Wiener, J. Tilly and S. Goldenson, “Federal and State initiative to jump start the market for private long-term care insurance,” *The Elder Law Journal*, Vol. 8, January 2000, pp. 58-99.

- *Moral hazard* – This is a typical problem associated with private insurance. Once insured, individuals may adopt behaviour that leads to an increase in the consumption of care services. In the context of long-term home care, people may, for example, use their insurance to pay for housekeeping services which, in the absence of subsidized assistance, might be undertaken by informal caregivers.
- *Anti-selection* – This is the over-representation of high risks in the insured population. Many individuals with a high risk of dependence tend to take out LTC insurance policies, whereas the contrary is true of low-risk individuals. Persons may not disclose all their health information to the insurer so as to maximize insurance coverage while reducing their costs. To deal with this problem, insurance companies select their insureds and refuse to insure those who most need insurance.
- *Intertemporal risk* – There is a relatively long period of time between the sale of an insurance policy and the payment of claims; and there are uncertainties relative to life expectancy, trends in the management and use of health care and, especially, health care costs. VPI is thus probably one of the riskiest insurance products that an insurer can put on the market. In the circumstances, the pricing of VPI for LTC is likely to fluctuate widely.

B. Private Insurers' Difficulty in Estimating Probability of Seriousness and Cost of Dependence

Unlike life insurance, for which only a mortality risk distribution table is used to establish claim levels, dependence insurance is based on tables indicating the transition between three states: good health, dependence and death. In addition, there are varying degrees of dependence (as many as six); these are based on a conventional and arbitrary distinction, they may vary from country to country (despite the standards established by the World Health Organization) and they may be interpreted differently by private insurers wishing to protect themselves from uncertainty by restricting their criteria.

In addition to the uncertainties facing actuaries who must work with very limited data on the various degrees of dependence when establishing their actuarial liability,⁽³⁷⁾ there are uncertainties regarding the long-term unit costs of those degrees of dependence. For insurers, this aspect of LTC complicates the drafting of adequate provisions to meet future claims and, consequently, the process of setting premiums. Furthermore, it is hard to predict the costs associated with treatment for the various degrees of dependence, which may vary considerably in future based on labour costs (which are a key element in the care of dependent persons), technological progress and public policy.

(37) Assous and Mahieu (2001), p. 25.

These difficulties inevitably lead private insurers to offer insurance policies that leave the insured with a significant portion of the risk. The exclusion of certain classes of high-risk persons, the application of specific definitions of dependence, and making the payment of benefits subject to waiting periods and deductibles are common practice. In addition, benefits are often lump-sum amounts not fully indexed to the rising cost of care.

A MODEL FOR CANADA

In the wake of the Kirby Committee and Romanow Commission reports, Canada is preparing to make important choices for the future of its health system.

In the home care sector, both the Kirby Committee and the Romanow Commission have recommended that a significant amount (approximately \$1 billion) be invested in the provincial and territorial home care systems. As regards funding, the Kirby Committee recommends that the proceeds from a progressive specific tax be placed in a reserve to fund all of its health system reform proposals, while the Romanow Commission advocates a new federal transfer to the provinces and territories reserved exclusively for home care.

These proposals were welcomed by all those experiencing dependence on a daily basis. However, in view of the “immensity” of present and especially future LTC needs,⁽³⁸⁾ the question once again arises as to whether the positive impact of this new contribution will be sustainable. It is indeed very likely that this new injection of funds will not put an end to waiting lists and that priority will still be given to those who are most financially and socially disadvantaged. In that case, the problem of accessibility, the main weakness in our health care model, would remain virtually unchanged. More specifically:

- Even if all aspects of home care were added to the *Canada Health Act*, the supply of care would continue to be restricted in the medium term by a shortage of skilled labour.
- Reform would very likely involve hiring new employees in the public sector, most of whom are currently employed in the community, volunteer and private for-profit sectors. As employment conditions are much less favourable in those sectors, a portion of the new amounts allocated to home care might be absorbed by wage upgrades for the new public

(38) In Canada, the value of care provided by family members and volunteer workers to dependent persons and persons losing their independence is between \$5.1 and \$5.7 billion a year, according to a study conducted on the basis of 1996 data (Janet E. Fast and Judith A. Frederick, “Informal Caregiving: Is it really cheaper?” a paper presented to the International Association of Time Use Researchers Conference, Colchester (U.K.), 6-8 October 1999). The Romanow Commission states in its report that the total value of services provided by informal caregivers ranges between \$20 and \$30 billion a year.

sector employees. If the *quality* of care provided improved as a result, the net effect on the *volume* of care might well be less than expected.

- If home care is covered by the *Canada Health Act*, the user fees and – especially – the service quotas imposed by certain provinces will have to be eliminated. In the end, there is a significant risk that waiting lists will grow, inasmuch as the elimination of quotas would not make it possible to spread limited resources among a larger number of beneficiaries.

Ultimately, and because of the nature of their mandates, both task forces advanced essentially ad hoc solutions to the under-funding of the home care sector. More comprehensive solutions are now needed to address the vast structural problem of an aging population, which is the primary source of the demand for long-term home care. In this context, any home care reform should be able to answer the following two basic questions:

- 1) How can we fund LTC, or enable the public to pay for LTC, so that people can get the care they need at the right time?
- 2) How can we guarantee the public an adequate supply of home care, and more particularly LTC, now and in the future?

These questions point to a consideration of the appropriateness of a social insurance model, such as those in Europe and Japan, for caring for persons who have lost their independence. Some countries where the increasing dependence of an aging population has long been debated have put complex systems in place to address the issue.

The insurance fund model is not unknown in Canada, although the country applies the tax funding model to health care. The Canada Pension Plan (CPP) and Quebec Pension Plan (QPP), the Employment Insurance program, the Commissions de la santé et de la sécurité au travail (CSST – Occupational Health and Safety Boards), and the Société d'assurance automobile du Québec are examples of public funds financed by specific contributions in order to share specific risks.

With regard to the funding of care for long-term dependence, the social insurance model offers many advantages over the tax funding model: protection against political factors, sensitivity to clients' needs, transparency for those insured, stable funding, and so on.⁽³⁹⁾ In addition, according to the Organisation for Economic Co-operation and Development (OECD),

(39) See “Social Insurance Model,” above.

of all fiscal levies with the exception of consumption taxes, social contributions have the least impact on total production in an economy.⁽⁴⁰⁾

The strongest argument in favour of a social insurance model for insuring against dependence risk⁽⁴¹⁾ is that it is, without doubt, the best way to address the intergenerational aspect of dependence. Canada's present system of funding through taxes – under which current tax revenues pay current expenses – does not meet Canadians' needs, and there is a real risk that an ever-increasing portion of public resources will be monopolized for that purpose. Debt and a return to budget deficits are not an acceptable solution to the problem, since that would be tantamount to having services provided to the present generation paid by future generations with no guarantee that they, in turn, would receive the same consideration. VPI plans are generally unable to provide universal coverage and, given the cost of premiums, are available only to the most well-to-do.⁽⁴²⁾ According to one analysis of the situation:

The only way to insure this kind of risk is through provident schemes involving contributions or premiums spread over part of the life cycle, whereas benefits are more concentrated toward the end of life.
[translation]⁽⁴³⁾

The other factor in favour of a social insurance fund is that households are not provident enough and do not save enough for retirement, despite the introduction of RRSPs.⁽⁴⁴⁾ They rely mainly on governments to support them if they become dependent. However, the probability of spending one's later years in a dependent situation is approximately 40%.⁽⁴⁵⁾ Thus, one way or another, it may be assumed that governments have a strong incentive to intervene to prevent what could well become a social disaster.

(40) OECD, *Revenue Statistics 1965-2000*, Paris, 2001.

(41) The Clair Report discusses an old age insurance plan (Commission d'étude sur les services de santé et les services sociaux du Québec, report tabled in Quebec City, 18 December 2000, p. 381).

(42) See section on voluntary insurance, page 13.

(43) Pascale Breuil-Genier, "La gestion du risque de dépendance : le rôle de la famille, de l'État et du secteur privé," *Économie et statistique*, No. 291-292, 1996, pp. 103-117.

(44) According to Statistics Canada, only 6.3 million Canadians out of a workforce of more than 15 million persons contributed to an RRSP in 2000. In that year, in a period of serious economic problems, the median contribution was only \$2,700. Similarly, at the end of 1999, nearly 5.3 million workers were members of a registered pension plan (RPP) established by the employer; that is, only 41% of paid workers in Canada.

(45) Commission d'étude sur les services de santé et les services sociaux du Québec (2000), p. 381.

A social insurance fund is all the more attractive since some of the disadvantages of, for example, the German model – many of which reflect the circumstances of its development – could fairly easily be corrected.

- If social insurance funds, financed through payroll contributions, can undermine employment and corporate competitiveness, there is nothing preventing a potential *Canadian model* from limiting contributions to employees alone.
- If payroll contributions exclude a segment of the population, a progressive annual contribution based on income, with or without a ceiling, could make it possible to extend coverage to all, including those who are unemployed or not in the workforce. Beneficiaries could even be asked to contribute while receiving benefits.
- Consideration could be given to capitalizing the entire plan in order to provide for future needs.

Dependence benefits could perhaps be added to the retirement benefits paid by the CPP and QPP, so as to avoid creating a new administrative structure. As is the case in France and Germany, the institutions or regional plans would assess dependence levels, forward the relevant information to the CPP or QPP for payment of benefits, monitor quality of care and so on. This would help to avoid the problems associated with the client-based approach, including those relating to diversity of membership criteria and benefits offered and portability of coverage, which are frequent in countries that have several different health insurance funds.

As is the case in Germany and France, an enhanced capability to pay for LTC, supported by an adequately funded system, could be a key element in developing the supply of services and improving the working conditions of employees in the sector, given that care providers could be expected to increase in quantity and quality within a well-regulated framework. A higher degree of professionalism would obviously be more expensive, but it would benefit both care recipients and the sector as a whole. The terms and conditions of the provision of benefits (in the form of services or cash), the private sector's place in funding and delivering services, and other factors should be defined on the basis of political and economic constraints and of the consensus that the various stakeholders in the sector will try to reach.

APPENDIX

THE PATTERN OF HOME CARE IN CANADA

A. Sharply Rising Expenditures

Over the past 20 years, home care expenditures in Canada have increased exponentially, at an average annual rate of 11.3%. In 2000-2001, those expenditures (public and private) totalled nearly \$3.5 billion.⁽¹⁾ Between 1980-1981 and 2000-2001, home care expenditures as a percentage of total health care spending in Canada rose from 1.2% to 3.5%.

Over the same period, home care expenditures by the provincial and territorial governments rose by a factor of 13, from \$205 million to \$2.7 billion,⁽²⁾ while their total health spending almost quadrupled, from \$16.4 billion to \$63.3 billion.

In 2000-2001, nearly 23% (\$764 million) of total spending on home care services was attributable to the private sector. Since 1980-1981, private sector expenditures have risen by a factor of eight.

This trend is likely to continue; it is anticipated that home care expenditures will increase by approximately 80% by 2026.

B. Major Increase in the Population Aged 65 Years and Over

The increased demand for home care and support services is fuelled by an aging population. Research has shown that the use of home care increases with age and degree of disability. It is projected that the number of persons 65 years and over, which was 12.5% of the population in 2000, will increase to more than 21% of total population in 2025.

Statistics Canada reports that, in 1996, approximately 95% of persons 65 years and over lived at home. According to the National Population Health Survey conducted in 1998-1999, some 400,000 elderly persons, or 12% of those in that age group, received care under provincial home care programs. Persons 85 years and over relied most on home care (37% of persons in that age group, compared to 20% for the 80-84 years group). The probability of disability increases with age: in 1991, 35% of disabled persons were over 65 years of age.

(1) Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01 – Statistical Annex*, August 2001, provincial and territorial government and private sector expenditures.

(2) *Ibid.*, Table 22A.