Documenting health reforms in Canada

Who pays what and who should pay?

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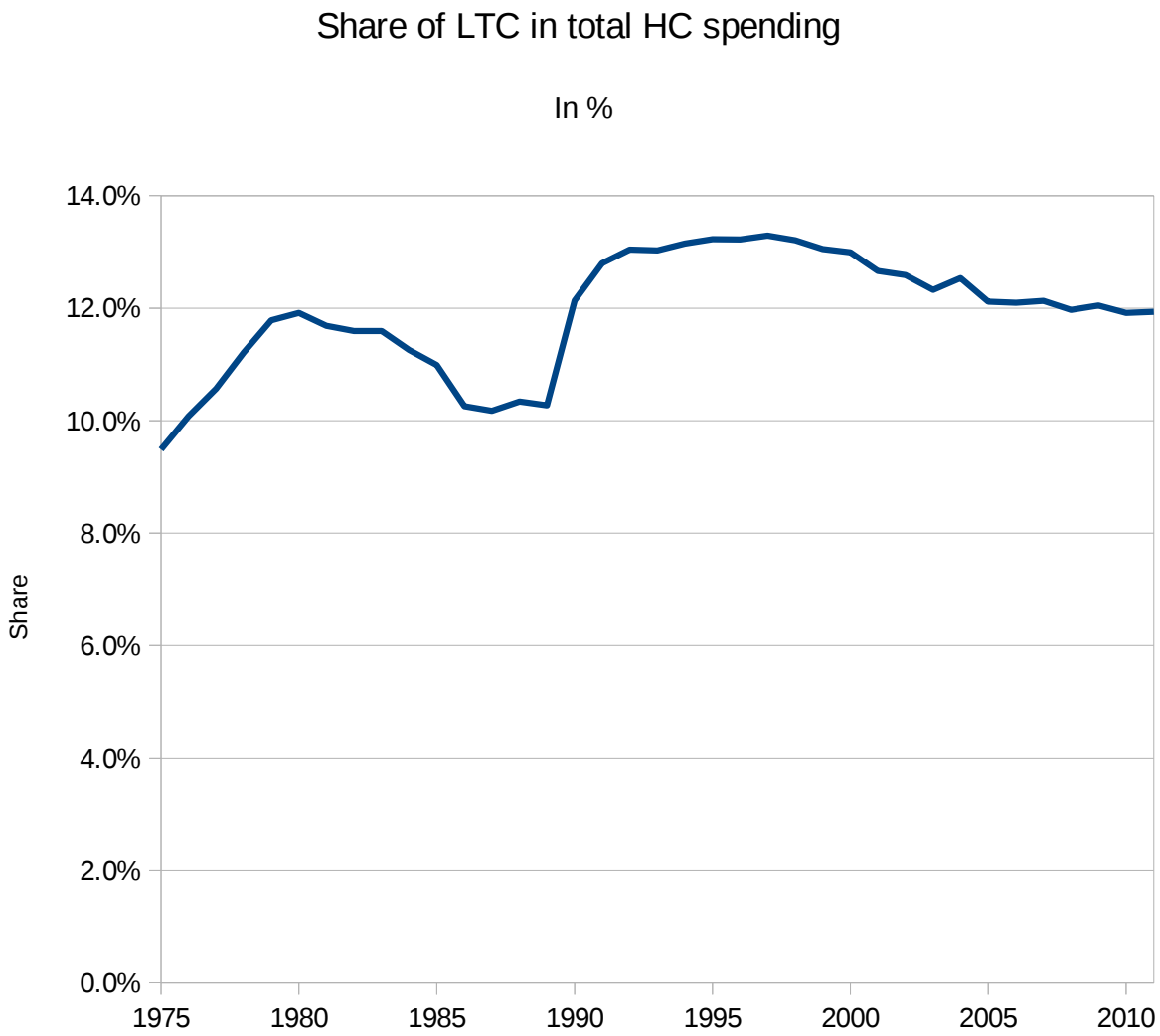
Total cost
Range of estimates

- Narrowest definition: $23.9 bn (2011) or 11.9% of THE.
- Was 9.5% in 1975.
- Adding municipalities and home support: $25.4 bn (2011) or 12.7% of THE.
- Was 12.0% in 1984.
- Adding LTC in hospitals: $29.5 bn (2011) or 14.8% of THE.
- Was 16.7% in 1990 (it is not all increase, there is also substitution)
- Source: SHI project, Health Canada.

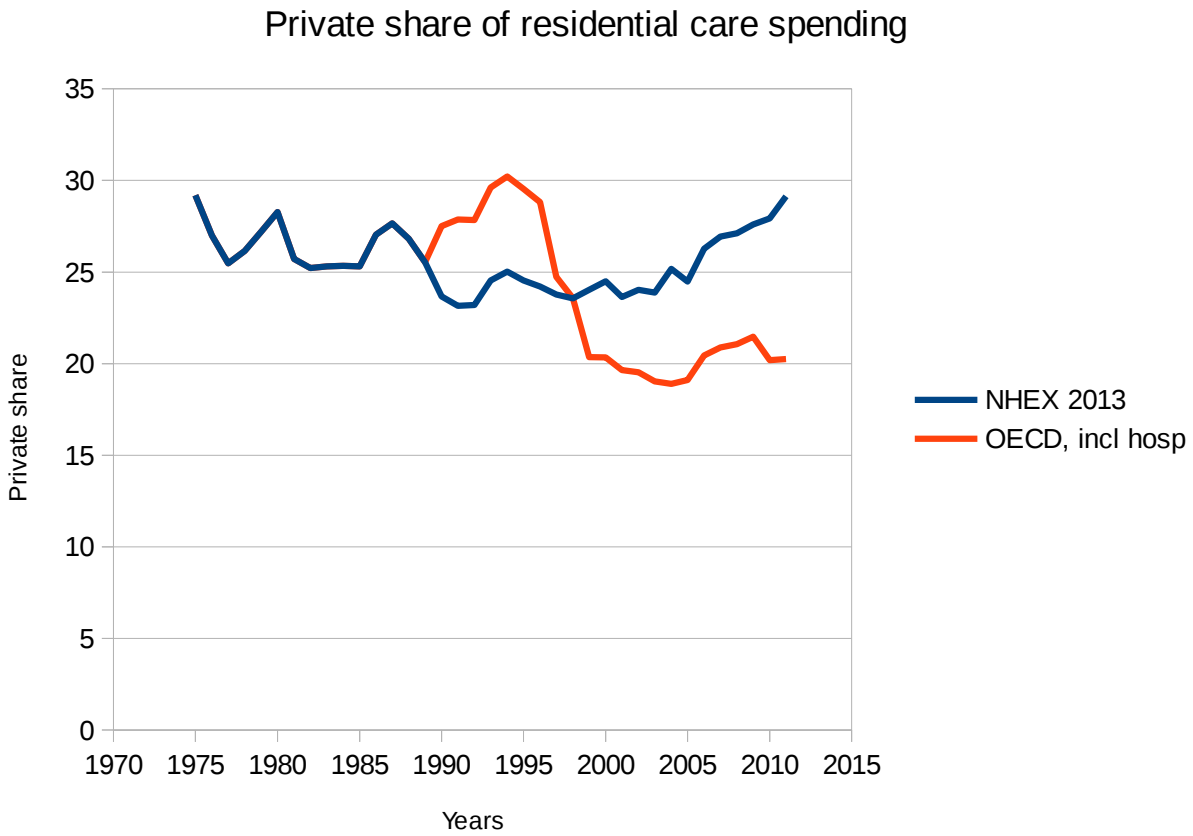
Time series not monotonically increasing



Who pays what?
Public/private divide

- Private share represents 20.2% of total spending on home care, almost all o-o-p (PHI only 0.4%).
- Was 42% in 1975
- Private share represents between 20.2% (OECD, incl. hospitals) and 26.5% (NHEX2012) of residential care, not much from PHI.
- Was 29.2% in 1975 but no clear trend.
- Public means P/T (but definition matters: payer is who distributes monies).

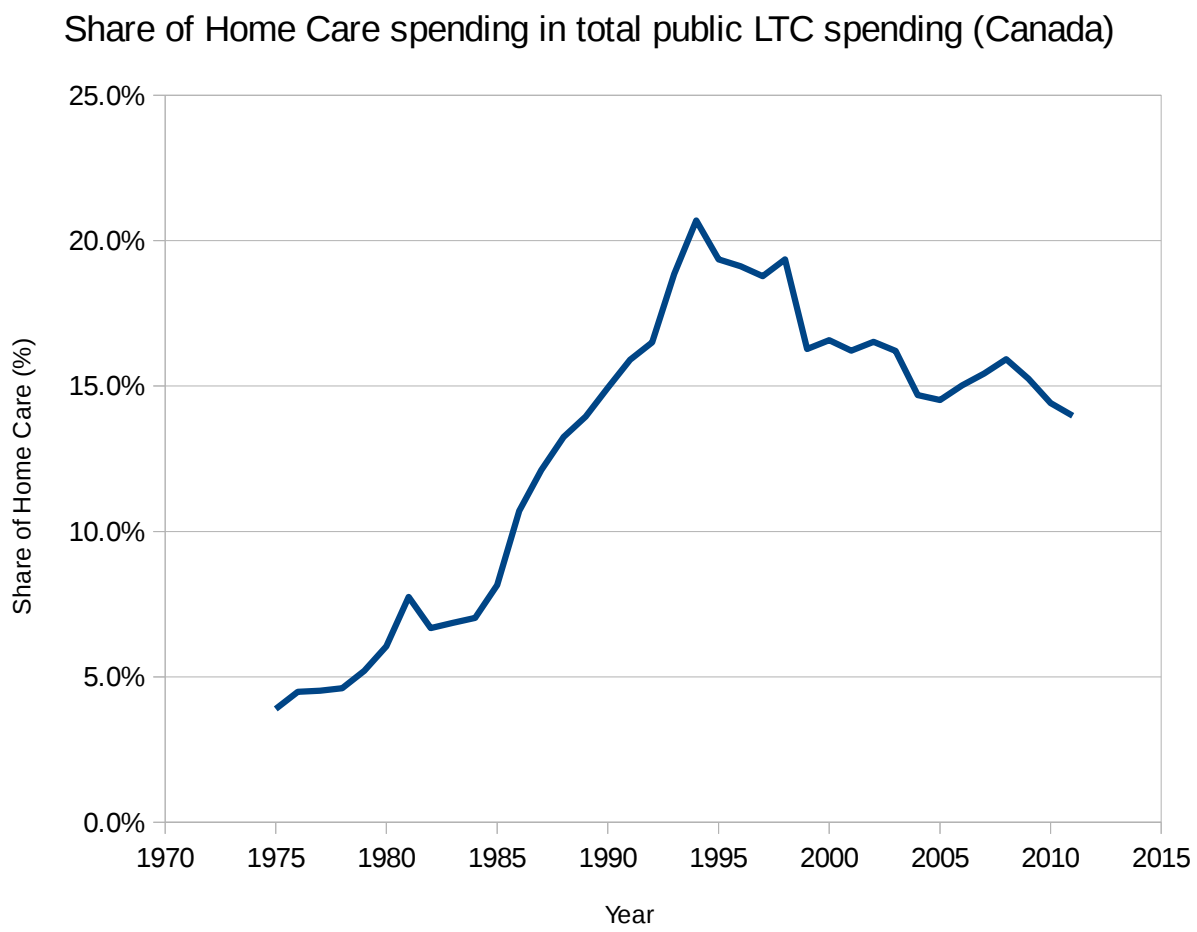
Time trend not clear



What does it pay?

- Mostly residential care
- Home care represents 14% (OECD definition, LTC in hospitals included) of TLTCE.
- Was only 4% in 1975.
- Again, no clear trend.

Share of home care: OECD definition, including hospitals



Who should pay? (1)
Private financing does not work

- Issue 1: Good Samaritan effect
  1. public safety net crowds out private LTCI
  2. hence private LTCI works well if no safety net provided
  3. what happens to those who cannot afford it (20%)?
- Issue 2: Systemic risk
  1. long-term insurance: start payment at around 50, claim at around 80
  2. policy lapses frequent: insurers cannot provide lock-ins (risk premium)
  3. unit cost follows random walk: no LLN, insurers are risk-averse.

Who should pay? (2)
Co-payments are not always right

- Acute care: insurance protects consumption
- Long-term care: insurance guarantees access
- Implication: if you need LTC, you don't need anything else
- Empirical question: is MUI 0 when dependent?
- My guts tell me: MUI increases when dependent.