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One of the most vexing challenges that Canada faces both now and in future is the sustainability of our publicly financed health care system. There is widespread concern about the relentless pressures on health care, which comprises the largest component of provincial and territorial budgets.

The report *National Health Expenditure Trends 1975 to 2012* found that total spending on health care in Canada was forecast to reach \$207 billion in 2012, averaging \$5,948 per person [CIHI 2012]. The good news is that the pace of expenditure appears to be slowing. Growth in health care spending as a percentage of the overall economy has declined over the past three years. The proportion of Canada's gross domestic product (GDP) spent on health care was estimated at 11.6 percent in 2012 – down from 11.9 percent and 11.7 percent in 2010 and 2011, respectively.

Provinces and territories assume primary responsibility for health care, which accounted for an average 38 percent of their spending in 2011, the latest available data. The proportion varied among the provinces from 30.1 percent in Quebec and 35.8 percent in Saskatchewan in that year to 44.3 percent in Manitoba and 47.9 percent in Nova Scotia [CIHI 2012].

Like most developed nations, Canada has a rapidly aging population. By 2036, 25 percent of the population will be over age 65. But contrary to popular belief, population aging has been a modest cost driver overall, accounting for a mere 0.9 percent of average annual growth in health care spending from 2000 to 2010 – though the cost impact varied by province. It was more significant in the Atlantic provinces and Quebec than in Ontario and the west because of the disproportionately higher rates of seniors in the former regions.

While the proportion of overall health care spending due to aging is relatively modest, expenditures do tend to rise with age. In 2010, the latest year for available data by age group, per capita spending was \$6,223 for Canadians ages 65 to 69, \$8,721 for those 70 to 74, \$12,050 for those 75 to 79 and \$20,113 for those 80 and older [CIHI 2012].

Although seniors in Canada have a relatively long life expectancy, many live with at least one chronic health condition. The Canadian Life and Health Insurance Association argues that these two trends together – longer life expectancy combined with at least one chronic health condition – will result in a dramatic increase over the next 35 years in the need for long-term care (discussed below). According to Statistics Canada, the chances of requiring long-term care are one in ten by age 55, three in ten by age 65 and five in ten by age 75. In short, Canadians have a 50 percent chance of requiring long-term care by age 75 [CLHIA 2012].

The Canadian Life and Health Insurance Association estimates that the cost over the next 35 years of providing care to baby boomers will be almost \$1.2 trillion (in current dollars) [CLHIA 2012: 5]. Government programs will likely cover only about half of this cost. As a result, Canadians will face a long-term care funding shortfall of close to \$590 billion – or about \$54,000 for each baby boomer in Canada today.

Given this vast sum, there is no shortage of reports raising red flags about the heavy costs, both now and in future, of health care in Canada. Various remedies to hold the reins on spending include shifting funds from acute care to chronic care, seeking hospital efficiencies, introducing innovations in treatment and de-listing insured services formerly covered under medicare.

Health care innovations are especially important, given the multiple problems embedded in the current system. The US-based Institute of Medicine found that “\$750 billion is squandered in that country every year on over-treatment, byzantine paperwork, fraud and other wasteful habits” [Picard 2012: A7].

Selected innovations are, indeed, starting to effect noteworthy shifts. There has been modest success in enhancing the quality of care through improved communication and coordination among parts of the health care system and between hospitals and community care agencies. Significant progress has also been made in delivering more effective community care and reducing costs through monitoring technologies and software programs that link, in real time, the formal and informal health providers engaged in the care of a given individual.

Another area that is ripe for innovation involves the reassignment of health-related tasks. With adequate training, many health care functions can be performed in the community by nurse practitioners or assistants, personal support workers or care attendants at lower cost than when provided by physicians. It is important to ensure, however, that the workers who carry out these crucial functions are paid a decent living wage. Innovation should not be equated with downward pressure on wages and working conditions.

In addition to innovation, the crucial condition that must be in place in order to tackle the financing challenge is to ensure that money actually matters. Concerns have been raised about the fact that the public administration of health care inadvertently can result in less attention to cost savings and efficiencies.

This paper argues that innovation, while vital, is not sufficient. Increased funding for health care – especially long-term care at home and in residential settings – is critical. If there are any new funds to be found, they should go to the delivery of community-based supports and services. The community support sector is so drastically underfunded right now that it requires a substantial infusion of dollars to improve both the quality and quantity of available supports, the need for which will only increase with an aging population.

The provision of any new funds for long-term care would have to respect key conditions. These include, for example, continuous improvement and innovation within hospitals and community agencies as well as between these two systems. Moreover, funds would be tied to demonstrated effectiveness and improved outcomes in terms of health and the quality of life, more generally.

In short, the receipt of any funds raised through new financing instruments in Canada must come with conditions for accountability and improved outcomes in health. It is not enough to say,

for example, that more services were delivered in a given period or that additional tests were carried out. In fact, excessive and unnecessary medical procedures actually can do more harm than good.

a. Current needs

There are at least three distinct health-related needs that generally get rolled up into one conversation. These relate to home care, long-term care and new technologies.

Home care is a term typically used to describe one specific service. In this context, however, it is being employed to refer to a cluster of services that enable independent living. These include:

- home health care for health-related functions, such as administering medications, changing bandages, cleaning breathing tubes and carrying out dialysis
- attendant care for the personal activities of daily living, such as feeding, bathing and dressing
- homemaker assistance for essential home-related tasks, such as shopping, cooking and cleaning.

These diverse tasks generally are undertaken by individuals having diverse qualifications, with health-related functions requiring the most training. The delivery of these services varies by province and territory, and by community. In some cases, these supports are grouped under a single umbrella. In other cases, they are provided through separate programs. Some jurisdictions organize these services into two distinct streams – for persons with disabilities and for seniors – while others combine them into a common program for both populations.

Provinces and territories may deliver these services directly and/or purchase them from nonprofit agencies and private businesses. The costs of services that relate primarily to health care typically are covered fully or partly by medicare. The delivery of supports that do not fall into the ‘medically necessary’ category usually requires cost recovery, which involves a sliding fee scale.

User contributions to the cost vary according to income. Beneficiaries of certain programs, such as social assistance or the Guaranteed Income Supplement for seniors, may be eligible for these services at little or no direct cost to themselves. They must have low incomes in order to qualify for these programs in the first place.

Caledon has made detailed proposals regarding the reform of these supports [Torjman 2007]. But problems with the quality of service are only one side of the equation. The other equally important concern relates to quantity. *These services are in short supply relative to rising demand.* There are simply not enough of them to go around. The situation is only expected to get worse with an aging population.

In fact, the rising incidence of multiple chronic illnesses is creating significant pressure on health care systems throughout the world. More people will be living longer with conditions that require ongoing supervision and some form of intervention, if only in the form of prescription drugs. The World Economic Forum estimates that five chronic illnesses – cancer, heart disease, diabetes, respiratory diseases and mental illness – will cost \$47 trillion on a global scale over the next 20 years.

As they age, most people would prefer to remain in their own homes for as long as possible. Recent polling by the Canadian Life and Health Insurance Association found that 77 percent of Canadians would prefer to stay in their homes as they age [Frank 2012]. Ontario and Manitoba have introduced strategies called ‘Aging at Home’ and ‘Aging in Place,’ respectively, to reflect this preference.

There must be a sufficient supply of community-based supports in order to enable aging at home. But some seniors eventually will require placement in a residential home or long-term care facility if their health-related needs become too great for care at home. There is a shortage of affordable, long-term care facilities in Canada. It is essential to explore options for additional revenues for this purpose – the sooner the better.

In Ontario, for example, 99 percent of the province’s long-term care beds were occupied as of July 2011. There were 19,000 Ontarians waiting for long-term care placement that year. While the average wait time for placement was 76 days, it varied widely by region. Of the clients placed in long-term care, two-thirds were in the high needs category and 28 percent were in the crisis category. Only thirty-six percent of residents were placed in the home of their first choice [Long Term Care Innovation Expert Panel 2012: 15].

Lack of home care options means that many patients cannot be discharged from hospital. An estimated 7,500 Canadians currently live in hospital because they have nowhere else to go. At an average \$1,500 per diem cost, total unnecessary hospital stays amount to about \$11.3 million *per day* – a sum that could help resolve the problem if it were directly invested in home care.

Another pressure on home care arises from the fact that many institutions for persons with disabilities were closed over the past few decades. This policy decision generally has been deemed a good thing. Unfortunately, the closures were not always accompanied by a sufficient supply of supports to enable a good quality of life for the individuals now living in the community.

A third challenge relates to the financing of home care, which effectively represents a blend of health and social services, depending on individual need. In the case of social services, in particular, the federal government used to provide an incentive for provincial/territorial investment through a transfer known as the Canada Assistance Plan (CAP). Under this arrangement, Ottawa contributed 50 cents of every dollar that provinces and territories spent on a designated list of social services that met certain criteria, such as nonprofit delivery.

In 1996, the Canada Assistance Plan was replaced by a new Canada Health and Social Transfer (CHST), a block fund for human services. The CHST also replaced Established Programs Financing (EPF), a block fund through which Ottawa had transferred cash and taxing power to the provinces for health and postsecondary education. The CHST brought with it large cuts in federal transfers – an estimated \$8 billion over the life of the arrangement until 2002-03. In 2004, the CHST was split into the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) intended for health and social services, respectively.

The withdrawal of CAP was particularly problematic for persons with disabilities. The end of 50-cent dollars as an attractive investment incentive meant new cost pressures for provinces and territories.

CAP was the mechanism under which many disability supports were financed. CAP shared the cost of homemaker services that allow people with disabilities and the elderly to live at home by helping them with their shopping, cooking, cleaning and other household tasks. In some provinces, CAP shared the cost of attendant services that help people with disabilities live in the community by assisting them with the personal activities of daily living – eating, bathing, dressing and grooming. CAP shared the cost of occasional relief or respite services for parents caring at home for children with severe disabilities. CAP shared the cost of medically-prescribed diets and medical supplies for certain households unable to afford these health-related costs. It also paid for wheelchairs, special eyeglasses and prosthetic appliances for people unable to purchase this disability-related equipment on their own [Torjman 1996].

All these contextual factors add up to one conclusion: There is not enough money in the pot to finance the range and scope of community services required now and in future. One possibility is to redirect funds from acute care to community care. The current ratio is seriously imbalanced. However, there are always costs involved in any transition when shifting staff and resources from one form of provision (in this case acute hospital care) to another (community care for chronic conditions).

Another way to ease the problem is to invest in the supply of long-term care. While this approach may help reduce the *availability* shortage, the *ability to pay* remains an equally pressing problem. Long-term care is expensive and can cost several thousand dollars a month, depending on the facility as well as type and level of care required.

The provision of long-term care involves both health care and the cluster of home care services earlier described. Medicare pays for treatment provided by physicians in hospitals or residential facilities. Other essential components of long-term care, such as room and board, are not covered by medicare. Procedures not reimbursed by medicare are deemed ‘extended health care services’ and are typically subject to a user fee.

For institutional care (in a residential care facility), in 2008 maximum annual charges for standard accommodation for non-married seniors were \$12,157 in Quebec, compared with \$33,600 in Newfoundland [Fernandes and Spencer 2010]. For home care, the current allocation of costs between public and private purses is not known, but in the late 1990s, 25 percent of nursing care and support services provided at home were being paid out-of-pocket at an estimated average cost of \$15,000 per year per patient [Grignon and Bernier 2012: 3].

In addition to the provision of care at home, there are costs associated with new technologies. The cost of these technologies must also be taken into account in the financing of long-term and community care.

Health technologies consist of several components. Some health technologies are required for the screening of medical or genetic conditions and for various diagnostic tests, such as electrocardiograms, mammography, colonoscopies, tuberculin tests, CT scans and cholesterol testing. Other technologies are used in the treatment process, such as laser surgery for cataracts, laparoscopic surgery for appendicitis or special pumps for the treatment of liver cancer. Still other technologies serve as a replacement for specific organs or their function, such as cardiac pacemakers.

Information and communication technologies allow the sharing of diagnoses and recommended treatments. The proverbial second opinion can be obtained immediately and from around the world. Technology also enables the remote performance of procedures; teams of specialists grouped together in a centre of excellence can carry out various procedures in remote areas and other cities or even countries.

Finally, there is a range of *technologies that enable independent living*, such as Bliss symbol boards for communication, and hearing and visual aids. Electronic monitoring devices are being used increasingly to assist independent living. These devices monitor bodily functions, such as blood pressure, pulse and glucose levels. They can also be programmed to set off an alarm or alert a designated contact in case of a catastrophic event, such as serious fall, heart attack or stroke.

b. Financing options

This paper puts forward several proposals for financing various forms of community care. The purpose of these options is to grow the fiscal pie by generating additional money for this sector.

The federal government might correctly argue that it is not constitutionally responsible for the provision of home care or long-term care in the community. It is true that Ottawa has no authority for its *delivery*. But there is nothing to prevent the federal government from using the primary lever at its disposal – the federal spending power – to support a new financing arrangement to help tackle a major national problem.

The proposals in this paper all move into territory that has not been adequately explored, let alone tested, in Canada. They require study of possible design options in order to determine various parameters, associated costs and administrative feasibility. But it is essential to have a robust public debate on this issue, which often gets curtailed by the ‘no-available-funds’ chorus before the discussion even starts.

While proposals outlined here represent new and untested forms of financing, these options are not intended to promote the privatization of Canada's health care system. Rather, their purpose is to secure the financial foundation of the system so that it can continue to provide high-quality services right now as well as support innovation and new treatment methods in future.

i. Public insurance

Some form of public or social insurance might be considered as a financing option to enable the purchase of long-term care, whether in a residential facility or at home. "A public insurance plan would ensure universal coverage of long-term care needs more equitably and efficiently than would other financing options, and it would be more consistent with the "aging at home" approach, which is favoured by seniors and governments" [Grignon and Bernier 2012: i].

Social insurances generally are employed in the event of a shared risk that affects a substantial proportion of the population – in this case, the provision of long-term care for the elderly. Several developed nations have in place a social insurance model to help pay for long-term care. By contrast, Canada's social insurance experience is confined to income security programs, which provide protection by pooling contributions against identified work-related risks such as unemployment, work injury and retirement. Benefits are paid if contributors fall victim to the risk for which they have 'purchased' protection.

There are three major social insurances in Canada: Employment Insurance (EI), Workers' Compensation and the Canada Pension Plan and its twin Quebec Pension Plan. The federal government is responsible for the administration of Employment Insurance and the Canada Pension Plan. Provincial and territorial governments run their own Workers' Compensation systems; Quebec administers the parallel Quebec Pension Plan.

Employment Insurance is intended to protect workers from the income insecurity associated with unemployment. EI premiums are deducted directly from employee wages. Employers also pay a percentage of their payroll for these premiums. Self-employed workers are not eligible for EI benefits.

Workers' Compensation provides income replacement and compensation resulting from accident or injury on the job. These programs fall under the auspices of provincial and territorial governments. Only employers are required to contribute to this form of social insurance.

The Canada/Quebec Pension Plan replaces earnings in the event of retirement or severe disability. Under this plan, workers contribute a percentage of their wages (up to about average earnings) in the form of premiums, called 'contributions.' Employers match the employee contribution. Self-employed workers are covered by the plan but pay twice the amount as both employee and employer.

Various proposals have been put forward for a social insurance plan to sustain and expand public health coverage in Canada [Grignon and Bernier 2012]. The funding of prescription drugs through a social insurance approach has been identified as a good place to start [Stabile 2012].

Another possibility is to employ a social insurance framework to finance long-term care. There is global precedence for this approach. Several countries, including Germany, Japan, Korea, the Netherlands and Luxembourg, provide universal coverage for long-term care through a plan that operates much like the Canada Pension Plan.

In Germany, for example, participation in the Long-Term Care Insurance Plan is mandatory. Since 2008, total contributions for the first €44,550 (\$55,257 Canadian) of annual income are 1.95 percent, split equally between employer and employee [CARP 2011]. Pensioners must contribute the amounts themselves and Unemployment Insurance covers the contributions for the unemployed.

Long-Term Care Insurance in Germany offers a number of benefit options, which can be adjusted according to need [Arnzt et al. 2007]. Every six months, recipients must choose cash, in-kind benefits or a combination of the two. Cash benefits are available for individuals who require lighter care or home care services. In-kind benefits are intended for people who require more intensive care in nursing homes.

Germany's Long-Term Care Insurance Plan also delivers benefits to family caregivers. They are eligible for up to four weeks' vacation during which the insurance plan covers expenses and pays a maximum €1,510 (\$1,873 Canadian). Family caregivers may take 10 days' leave or up to six months' unpaid leave from work to provide long-term care for a family member [CARP 2011].

Informal caregivers also have access to free educational and training courses. Those who work fewer than 30 hours a week and deliver care for at least 14 hours a week receive pensions through the Long-Term Care Insurance Program.

While a strong program, there are several problems that have been identified in the design of the German system. Because long-term care insurance is intended to make available only a baseline of care, many households purchase supplementary private long-term care coverage. As of 2009, more than 1.6 million Germans owned additional private insurance [CARP 2011].

Moreover, the program is not fully financed by premiums. These will need to rise in future as a result of the growing ratio of recipients to non-recipients.

Despite these challenges, a separate designated fund for long-term care would represent a substantial advance over Canada's system, which consists of a patchwork of programs supported through tightly-stretched provincial/territorial budgets and user fees. Another plus for the German system is its formal recognition of caregivers and the provision of benefits through the long-term care fund.

Of course, earmarked contributions should not be overused as a financing instrument. Governments need a large and solid pool of general revenues in order to meet their wide-ranging responsibilities.

ii. Individual savings accounts

Other financing proposals include individual savings accounts for the purchase of care at home. Unlike social insurances, contributions to these measures would not be compulsory. But the associated tax break would encourage Canadians to save for this purpose.

A new measure could be designed like a Registered Education Savings Plan or Tax-Free Savings Account. Ottawa could even make a contribution on behalf of low-income households, as it currently does for the Canada Learning Bond and Registered Disability Savings Plan.

Governments could create designated registered savings plans with tax exemptions on condition that the money saved is actually used for long-term care services. As with Canada's Registered Retirement Savings Plan (RRSP), tax exemptions could be offered at the front end: the portion of income saved in the medical savings account (MSA) would not be taxed, but withdrawals from the account to pay for long-term care services would be taxed. Alternatively, as with the Tax-Free Savings Account (TFSA), the portion of income saved in an MSA would be taxed, while the income generated by the fund would be exempted. MSAs have been in place in Singapore since 1984 (known as Medisave), although the scheme is used mostly to pay for acute health care services (Lim 1998) [Grignon and Bernier 2012: 6].

The Canadian Life and Health Insurance Association proposed a form of Registered Education Savings Plan (RESP) for long-term care:

In such a product, Canadians would be permitted to contribute a certain amount of money each year to save towards long-term care costs. Similar to RESPs, contributions by Canadians would be supported by grants from the Government of Canada. An RESP-type vehicle offers a number of advantages over alternative savings vehicles. All investment income generated in this type of savings vehicle is tax sheltered as long as it remains in the plan. Moreover, when the money is withdrawn and used for its intended purpose, the plan earnings and government contributions generally are taxed at a lower rate than they otherwise would be. Finally, because the government provides grants which help lever the individuals contributions, such a product is attractive for modest income earners for whom any tax deferral benefits are modest relative to those in higher income tax brackets [CLHIA 2012: 8].

iii. New fiscal instruments

There may also be fiscal instruments that have not yet been tested. Many seniors are cash poor but asset rich. Their residence or other asset could be used as the basis from which governments could provide an interest-free loan in respect of home care or long-term care. The loan would be repaid later through the proceeds of the estate.

Governments sometimes provide tax incentives for certain types of investments that they want to encourage, such as mining exploration and the development of the film industry. Some of these measures have had implementation problems. But as fiscal instruments, they represent a valid means of incentivizing investment in a crucial sector of the economy and society – in this case, long-term care.

Work is also under way in the country that is employing various forms of community bonds for social purposes. Community bonds are securities issued by a nonprofit organization to an individual or organization in return for an investment [Surman 2012]. These bonds represent a promise to pay the investor a specified rate of interest over the life of the bond and to return the investor's capital at the end of the term. Community bonds have been approved as eligible contributions to Registered Retirement Savings Plans (RRSPs) and Tax-Free Savings Accounts (TFSA's).

The Centre for Social Innovation in Toronto is a prime example of this type of investment. Created in 2004, the Centre offers shared workspace and services to more than 200 social groups, acting as a hub for people engaged in creative solutions to social problems. In order to accommodate the demand for its services, the Centre needed a second location. It was able to buy a property worth \$4.5 million through a loan guarantee from City Mortgage from Alterna Credit. An additional \$1.8 million was raised through community bonds [Surman 2012].

Different forms of community bonds are being employed for various purposes. The Renewable Energy Co-operative Ontario (TREC), for example, sold 450 shares to build the Toronto Wind turbine. The West End Food Co-op in Toronto sold shares for \$100 to help build a natural health food shop.

Conclusion

A robust system of home care and long-term care will necessarily involve improvements to and efficiencies within the existing health care system. But innovations to the acute care side of the equation will resolve only part of the financing challenge for long-term care. The community components of health care need more money if they are to meet current and future demands – in both quality and quantity of service.

New funding instruments for home care and long-term care are required over and above existing sources of revenue. The proposals put forward here are intended to contribute to the financing conversation, which itself is in desperate need of enrichment.

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