



Long-term Care Policy: Unlock the Deadlock

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« The statement “Oh Lord, I need a Mercedes-Benz!” is a joke. “Oh Lord, I need a coronary by-pass graft!” is not. »

Evans RG, Strained Mercy: the Economics of Canadian Health Care, Toronto, Butterworths, 1984.

« The sick person is...suffering...This is a very different kind of “need” from that of a person who merely “wants” something that he can be permitted to have if he can “swing” it independently, such as a new car... »

Parsons T, The Case of Modern Medical Practice, page 440-1, in The Social System, New York The Free Press, 1951



« So the United States government is owned by the 1%, directly or through the corporations these people control »

Evans RG, A Casualty in the Class War: Canada's Medicare, Healthcare Policy, 2012;7:14-22.

« ...la bourgeoisie, depuis l'établissement de la grande industrie et du marché, mondial, s'est finalement emparée de la souveraineté politique exclusive dans l'État représentatif moderne. Le pouvoir étatique moderne n'est qu'un comité chargé de gérer les affaires communes de la classe bourgeoise tout entière »

Marx et Engels, Le manifeste du parti communiste (1848), page 8,
<http://classiques.uqac.ca/classiques/Engels_Marx/manifeste_communiste/manifeste_communiste.html>



Three questions

- ▶ **Is LTC a “want” or a “need”, attuned to a Mercedes-Benz or to a coronary by-pass graft?**
 - ▶ **Are illnesses and disabilities so intricately intertwined that individuals experience acute care and LTC as events belonging to a single trajectory?**
- ▶ **Increasing LTC costs and aging:**
 - ▶ **How about “institutional ingenuity”?**
 - ▶ **Where to go?**
- ▶ **Why it is that LTC is not publicly and universally covered?**
 - ▶ **Or, why would the 1%, with access to excellent acute and long-term care (Evans, HCP 2012), pay more than their share of care for the 99%?**



What is long-term care?

- ▶ **“Long-term care (LTC) refers to health, social, and residential services provided to chronically disabled persons over an extended period of time.”**
- ▶ **Dotty P & AL, An overview of long-term care, Health Care Finance Rev., 1985;6:69-78.**



Wants or Needs?

What do we know and since when?

- ▶ **In 1975, more than 40 years ago, it was expected that...**
 - ▶ **“...about 1 of every 5 Americans aged 65 and over will need a combination of intensive and extensive social and health services....[and] about 1 of 6 older Americans who are not institutionalized are so impaired as to necessitate one or more types of direct social and health services...” (Tobin 1975);**
- ▶ **And in the '90s...**
 - ▶ **“...the frail elderly: They may have multiple chronic illnesses and require concurrent acute, skilled, and long-term care services...[C]arefully tailored working relationships will be difficult to develop if the proposals for segregated acute care and community long-term care systems are followed...[Then] service managers and providers will be unlikely to work closely with new service coordination agencies to ensure timely referral and smooth transitions, avoid overlapping services and cost shifting, [will end up providing and then reducing] community long-term care services to those with short-term disabilities, or allow the community long-term care system to support medical care” (Leutz & al 1994).**

Health status in frail elderly: Four latent classes

		Physical and cognitive problems	Mainly cognitive problems	Mainly physical problems	Some comorbidity
Reduced mobility	2+	85,9%	8,2%	27,2%	20,7%
Disability in ADL	2+	70,7%	9,7%	33,7%	4,2%
Disability in IADL	4+	98,9%	78,4%	10,3%	0,3%
Cognitive limitation	Severe	63,1%	76,0%	3,1%	5,0%
Comorbidity	3+	25,7%	4,5%	42,8%	21,4%
Total		23,0%	11,4%	35,6%	29,9%

Health and social service cost per day: Frail elderly [2015\$]

Average total expenditures 65+ in 2016: 31,78\$	Average	Physical and cognitive problems	Mainly cognitive problems	Mainly physical problems	Some comorbidity
Total cost	101,41 \$	144,49 \$	97,92 \$	99,02 \$	74,85 \$
Institutions	73,64 \$	109,00 \$	76,23 \$	68,45 \$	53,86 \$
Hospitals	49,71 \$	59,35 \$	41,21 \$	52,25 \$	42,76 \$
Waiting for NH	6,64 \$	16,62 \$	7,03 \$	3,33 \$	3,33 \$
Nursing homes	14,36 \$	29,02 \$	25,75 \$	9,65 \$	5,65 \$
Community	29,66 \$	36,54 \$	24,70 \$	33,25 \$	22,23 \$
Home help care	8,77 \$	11,95 \$	5,19 \$	10,17 \$	6,09 \$
Home care	9,14 \$	14,14 \$	10,61 \$	9,61 \$	4,58 \$
Physicians	0,85 \$	0,68 \$	0,67 \$	0,94 \$	0,94 \$
Prescribed drugs	5,71 \$	5,80 \$	3,65 \$	6,95 \$	4,88 \$

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- ▶ **Disabilities do not occur alone, but result from a process and have consequences;**
 - ▶ **Components of the process include multiple chronic diseases, physiological impairments, frailty, functional limitations, and personal and social disadvantages;**
 - ▶ **Trajectories of disabilities are characterized by acute episodes of chronic diseases, episodes of severe disabilities, periods of relapses, and of joint episodes of chronic diseases and disabilities;**
 - ▶ **Disabilities are experienced as components of an individual's global health status.**
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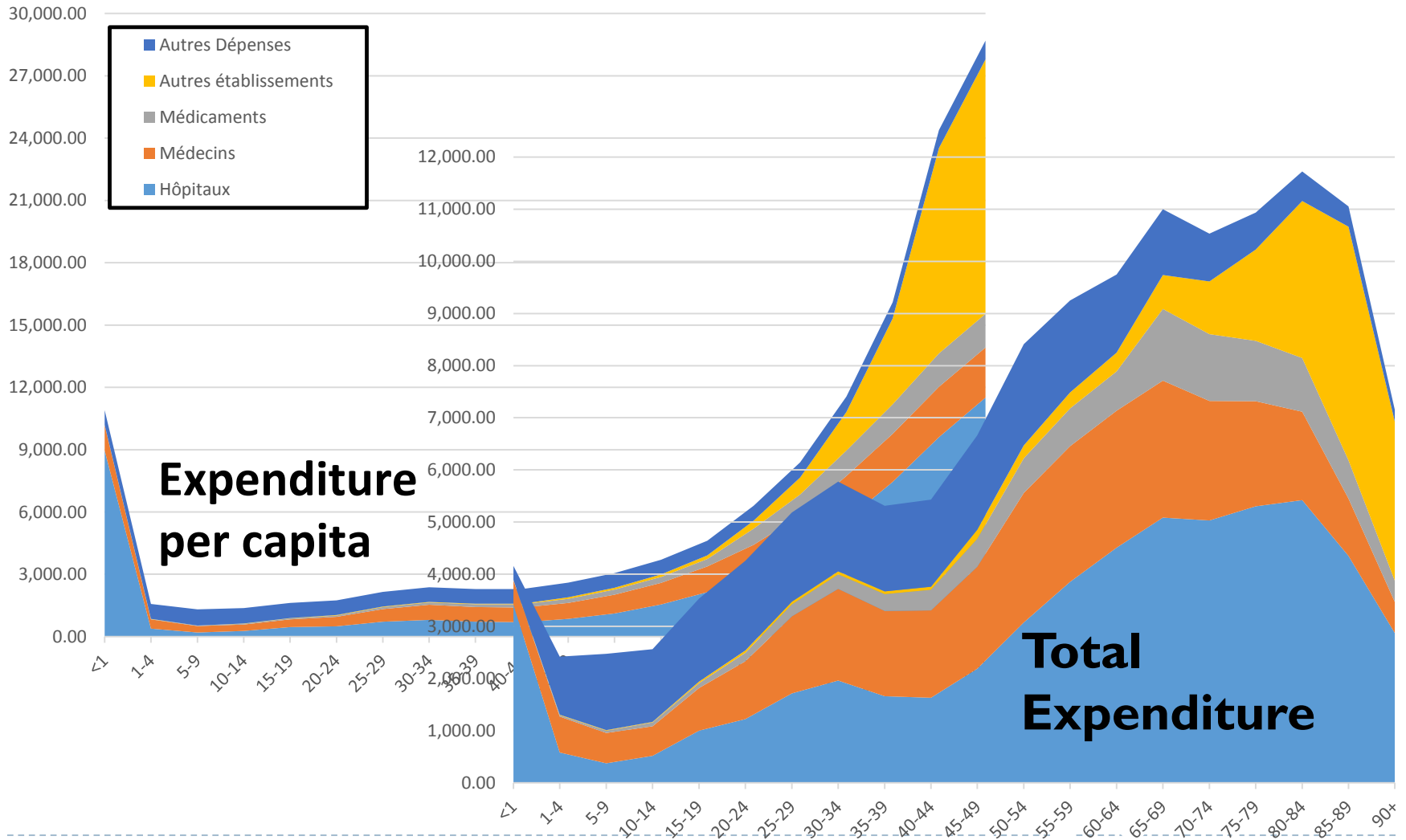




Data, Costs, People

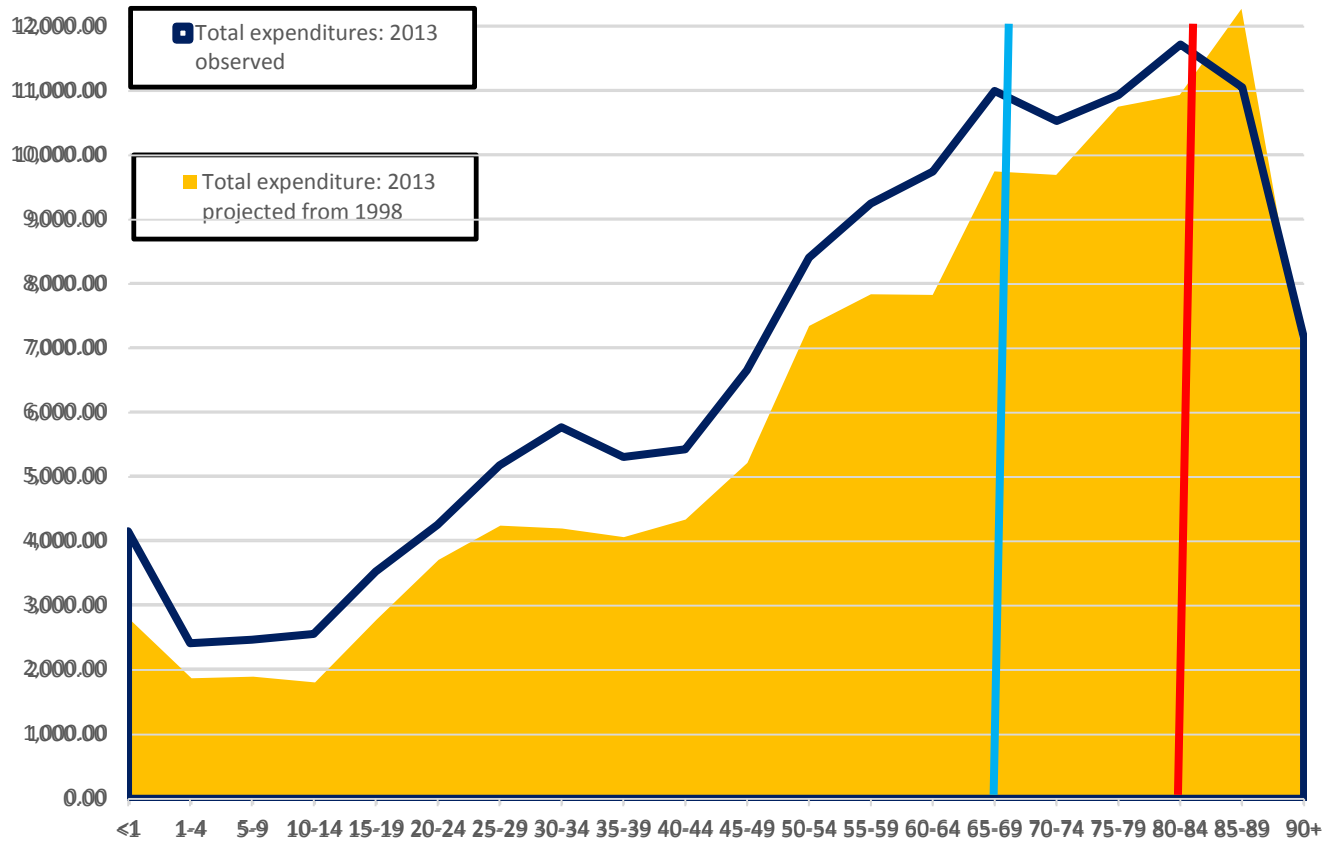
Use of health care by age: 2013

The "scary" and the "not too scary" versions



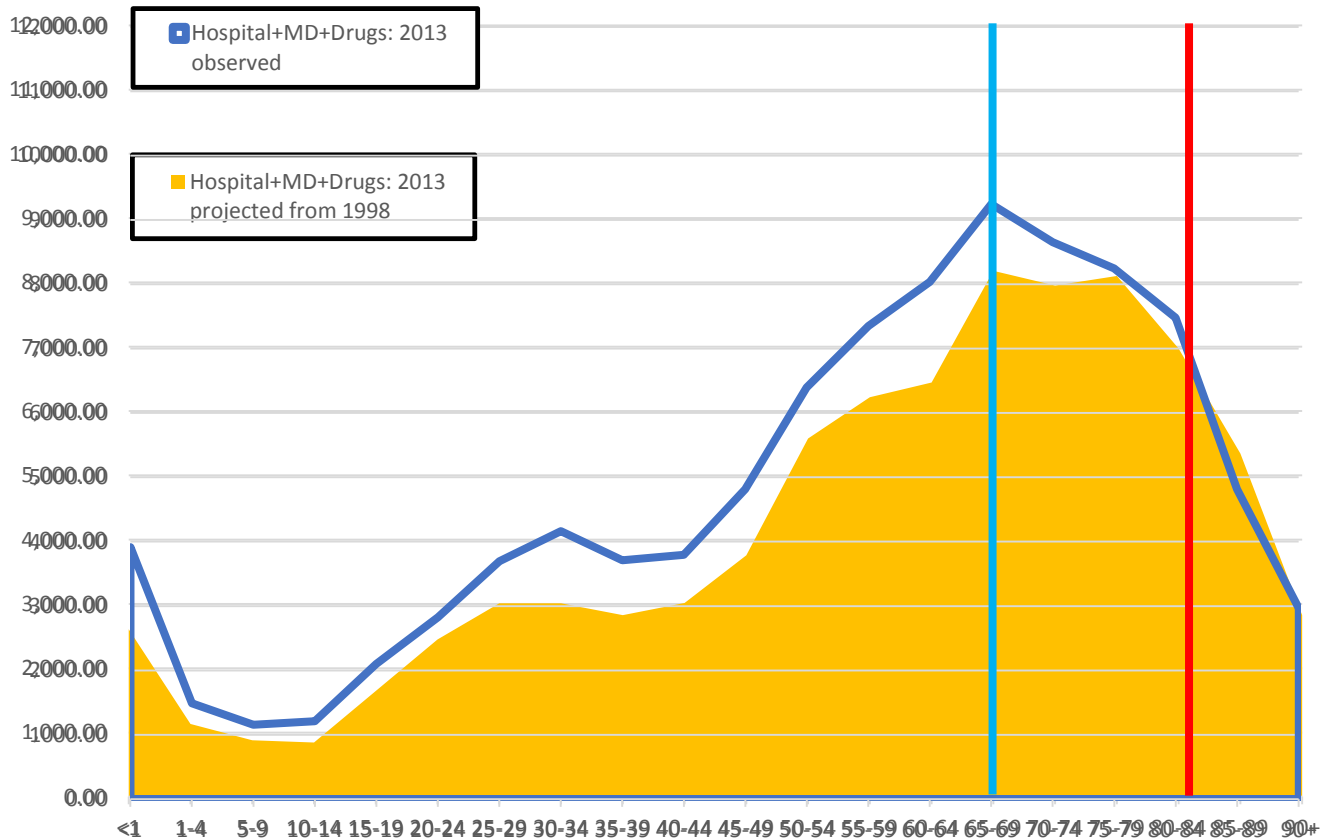
Total expenditure by age:

2013 obs. and 1998 proj. (with 2013 \$ and distribution within age groups)



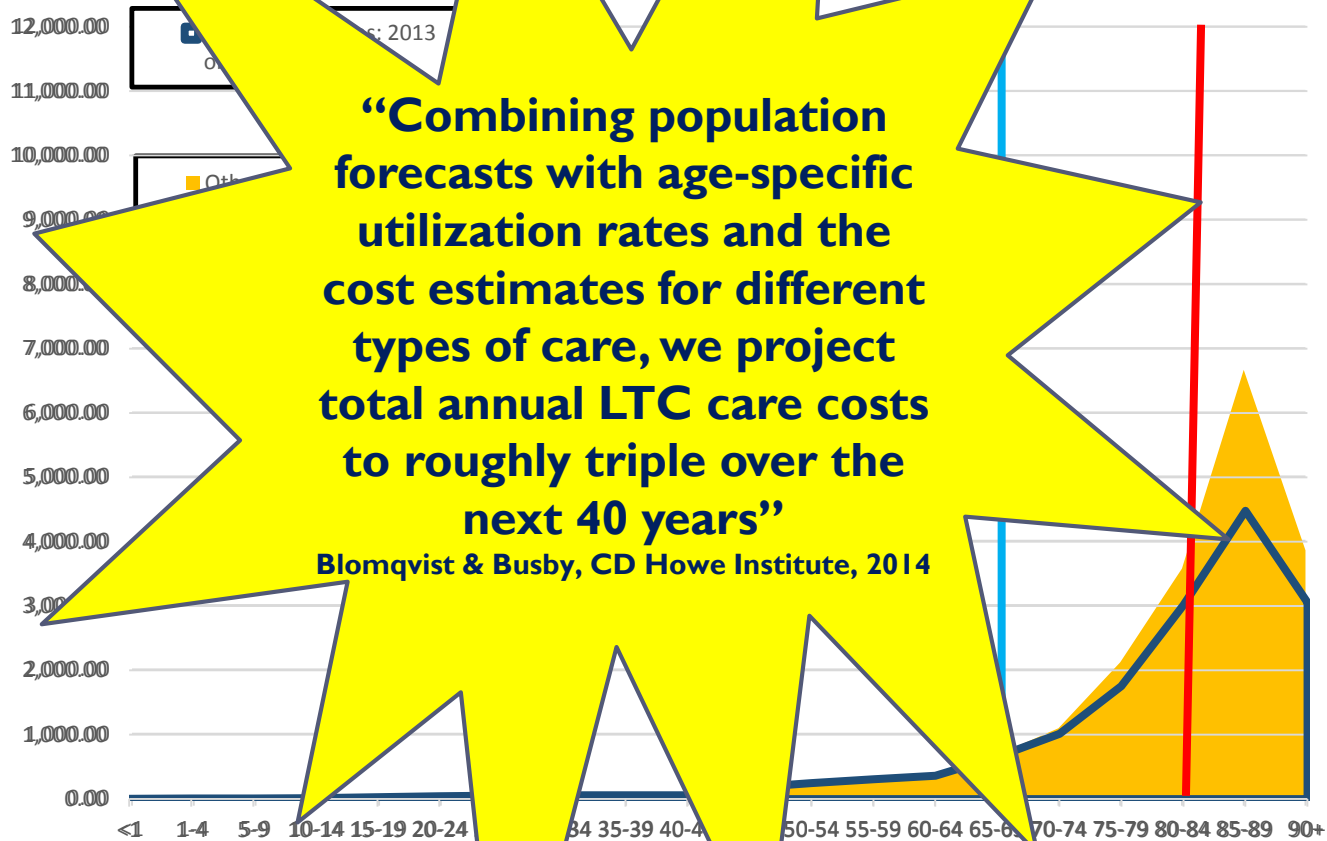
Medicare and Rx drugs by age:

2013 obs. and 1998 proj. (with 2013\$ and distribution within age groups)

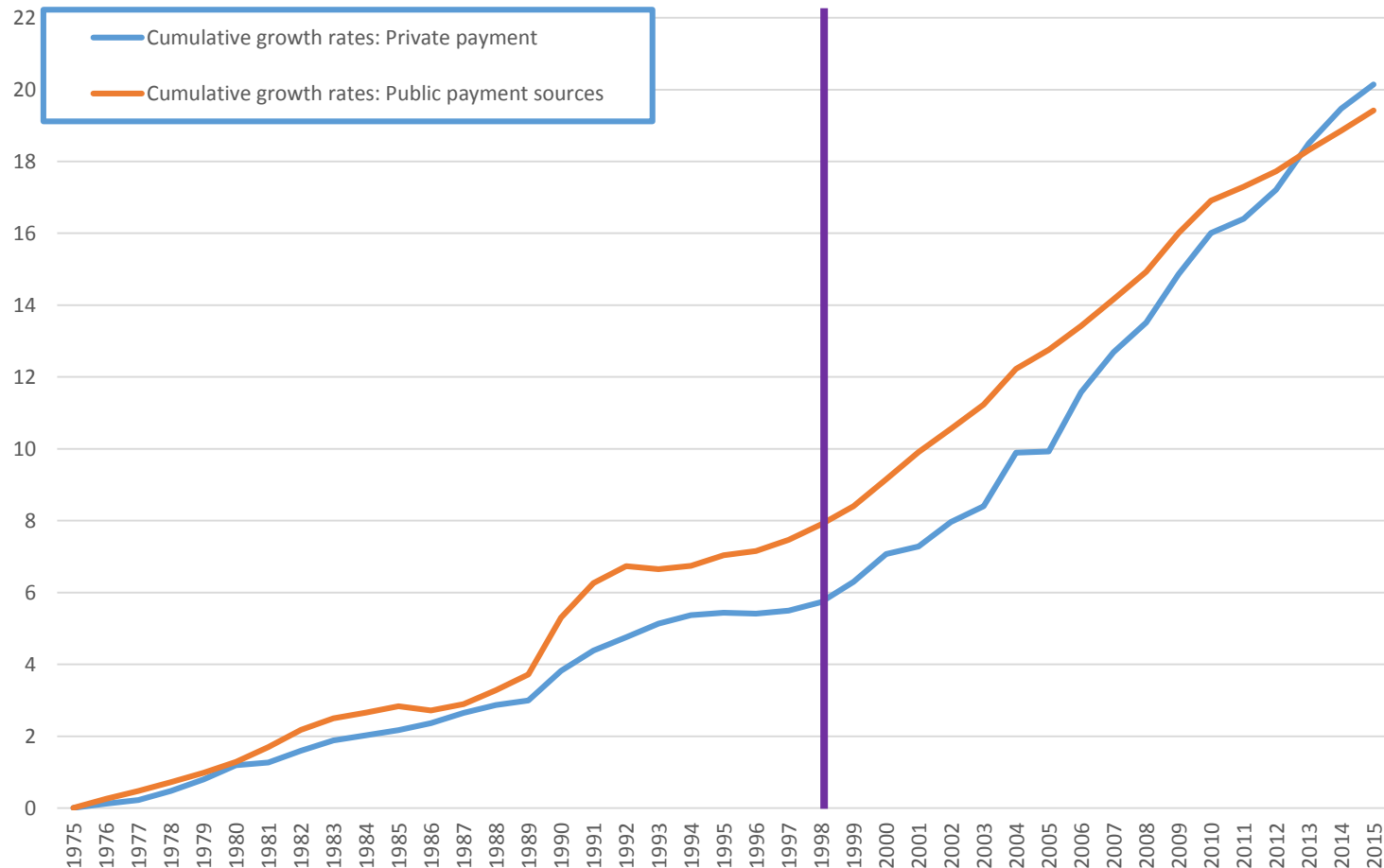


“Other institutions” by age:

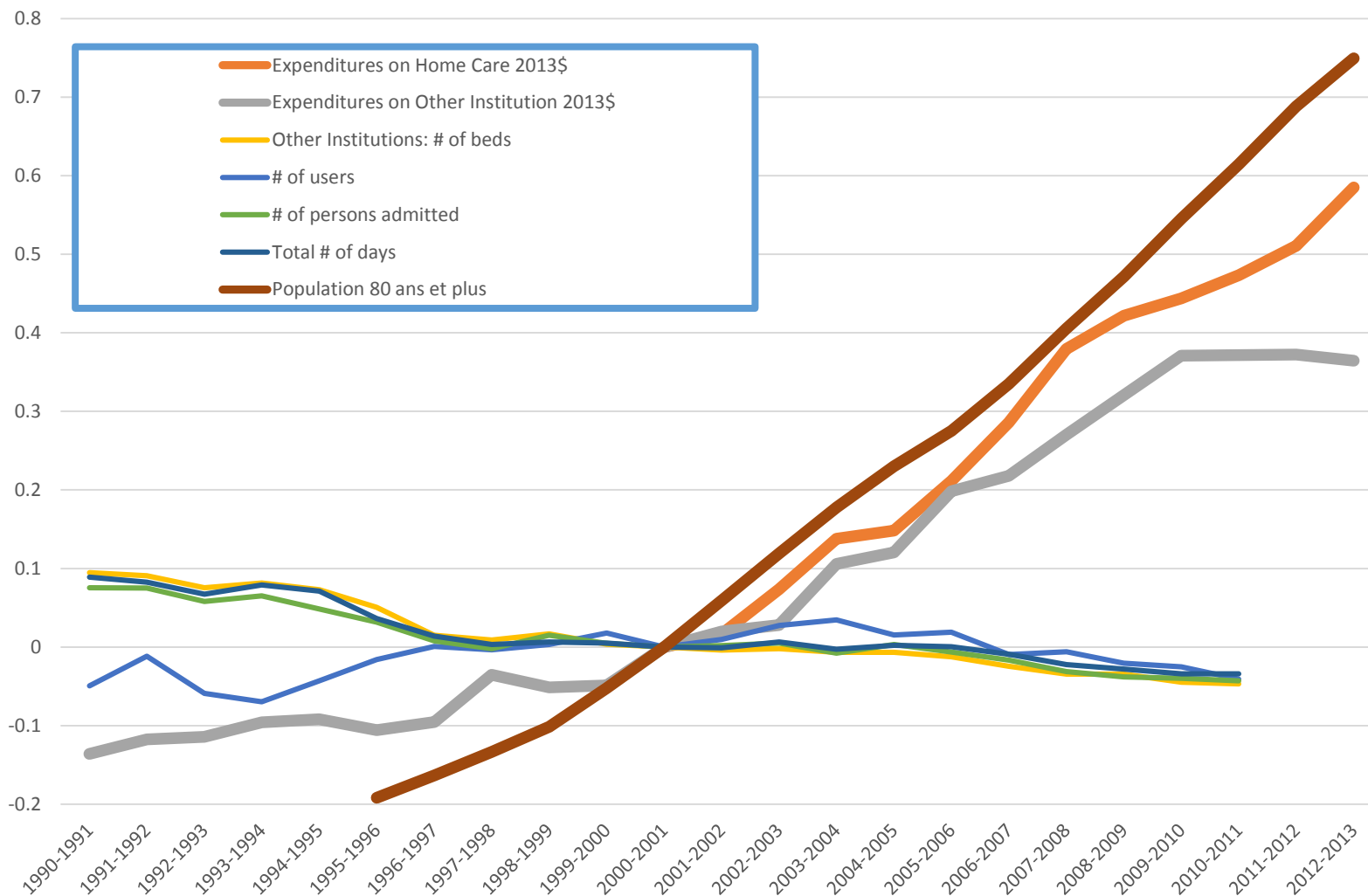
2013 obs. and 1998 proj. [with 2013 \$ and distribution within age groups]



Public and private expenditure on “other institutions”: Cumulative growth 1975-2015



Home care and nursing homes: Cumulative growth, Québec, 1990-91 – 2012-13





Insurance

The literature on LTC insurance from PubMed (first paper: 1983)

- ▶ **Early favorable outlook for private insurance:**
 - ▶ « **Government asks private sector to plug LTC gaps, Firshein J, hospitals, 1986;60:27-8;**
 - ▶ **LTC insurance: the race is on, Newald J, Hospitals, 1986;60:71.**
 - ▶ **Private financing options for long-term care, Brody BL & al, West J med, 1987;147:350-6**
- ▶ **Raising Doubts:**
 - ▶ **Options for LTC financing reform: public and private insurance strategies, Wiener JM, Illston LH, JLTCA, 1993:21:46-57.**



The literature on LTC insurance from PubMed

- ▶ **And then, here comes Pauly:**
 - ▶ **The Rational Nonpurchase of Long-Term-Care Insurance, JPE, 1990;98:153-168.**
 - ▶ “...the market for LTC insurance for the elderly is likely to remain relatively small...” (155)
- ▶ **Nevertheless, promoting private LTC schemes and studies on the reasons they do not flourish continues to this day:**
 - ▶ **Bloomqvist & Busby, Long-Term Care for the Elderly, CD Howe Institute, 2012:**
 - ▶ “Private insurance to help pay for long-term-care costs could be encouraged, especially for seniors who wish to pass on assets to their heirs, and might reduce the need for public subsidies to a limited extent.” (31)



My favorite literature on LTC insurance

▶ **And..RG Evans:**

▶ **Hancocked: Manulife and the Limits of Private Health Insurance, Healthcare Policy, 2011;7:14-21**

- ▶ “The problem? Long-term care insurance...What when wrong? Two things...one...demonstrates the fundamental weaknesses of private markets for health insurance...” (17;14)
- ▶ “...increases in life expectancies have been going on for over a century...these trends represent...*correlated* risks. Rising life expectancies raise the risk...associated with all the outstanding contracts...” (18-19)
- ▶ “In a discussion of source of “market failure” in private insurance markets, I once included “insufficient information for rate-making. Predicting needs for and costs of care over a time horizon of years or decades is virtually impossible...”(20)

▶ **And of course the Grignon and Bernier paper:**

- ▶ **Financing Long-Term Care in Canada, Montréal, IRPP, 2012.**
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**Concluding Remarks:
Principles and Principals**



Principles

- ▶ **Frailty is inextricably linked to illness, deficiency and functional limitation;**
- ▶ **The principles of finance, administration and management of LTC should be compatible with the requirements of a geronto-geriatric clinical model;**
- ▶ **The financing of services should allow for the mobilisation of resources and varied and complex services based on the situation of each individual;**
- ▶ **The risk of frailty should be assumed by the collective.**



Principals:

The use of Pareto by economists

- ▶ **The rational man and Pareto optimum:**
 - ▶ “Every individual, acting within logical norms, tries to achieve the maximum individual utility” TSG, paragraph 2131.
- ▶ **Institutional ingenuity:**
 - ▶ “Suppose [that public authority] acts logically, and with the sole intention of obtaining an assured utility [for the collective]...in summary, it would rudimentarily accomplish an action that only a pure economy could achieve with great rigor [to maximise the utility of individuals] ...” TSG, paragraph 2131.
- ▶ **The class war:**
 - ▶ “There is cause to investigate which proportions of different social classes enjoy [a universal and public LTC insurance], and in which of varying proportions they have acquired it by their sacrifices ...The governing classes often respond by confounding the problem of the maximum of the collective [Pareto optimum] with the problem of the maximum for the collective [the public good]” TSG, paragraph 2134.