REGULATING INDIVIDUAL CHARGES FOR LONG-TERM RESIDENTIAL CARE IN CANADA

Martha MacDonald

Abstract
Provinces and territories differ in how publicly regulated long-term residential care is financed. Although the costs of "care" are funded publicly, all provinces and territories except Nunavut require contributions from individuals to cover so-called accommodation costs. These vary widely. This paper examines trends and variations in long-term residential care fee structures and the implications for equity (within and across jurisdictions), including gender equity.

Long-term residential care in Canada, as in most Organisation for Economic Co-operation and Development (OECD) countries, though publicly regulated, is financed through a mix of public and private contributions. In this regard, it differs from other elements of the health care continuum. Indeed, it has not always been considered part of health care. Long-term residential care evolved as social care, not health care, and was not included in the *Canada Health Act*. Each province and territory has a particular history that shapes its approach to funding to this day. This paper examines variation across provinces and territories in long-term residential care resident charges, and the underlying principles that are manifested. The paper focuses on the equity implications of the fees and examines horizontal equity (in this case across provinces and territories), vertical equity (across the income distribution), and gender equity. This paper is part of research on promising practices in long-term residential care in five Canadian jurisdictions, the United States, and several European countries.[1]

While some residential care options exist only in the private sector (referred to as retirement homes or independent living), each jurisdiction in Canada provides public financing for some level(s) of residential care. All jurisdictions fund a category of facility that provides 24-hour nursing supervision for adults, primarily seniors. These facilities are variously called nursing homes (used here), long-term care facilities, homes for the aged, special care homes, personal care homes, or continuing care facilities. These publicly funded facilities may be publicly owned, private for-profit, or private not-for-profit facilities.

In general, provinces and territories have moved to providing public funding for programs that are universal, in that all people who qualify based on need are eligible for care. Each province and territory has a single entry access system whereby physical need is assessed, assignment to a facility is determined, and wait lists are managed. There is a mix of public funding (out of provincial revenues, including federal transfers) and private funding (charities, means-tested resident fees, and private insurance). Overall, about 70 percent of funding is public, though there are significant differences by province (as low as 55 percent and as high as 82 percent). Public spending on long-term residential care as a share of health dollars ranges from 5.1% in British Columbia to 15.8% in Nova Scotia. Manitoba, Saskatchewan, Newfoundland and Labrador, and Nova Scotia spend the most per capita, while British Columbia and Ontario spend the least.[2]

This article reviews the international literature about approaches to funding long-term residential care, in particular the rationale and structure of resident charges. It then summarizes the points of agreement across Canadian jurisdictions, especially concerning notions of fairness in resident charges. Various scenarios are presented to examine the implications for equity within provinces, across provinces, and by gender. Such comparisons pose methodological challenges even within the context of one country.

The analysis is situated within a feminist political economy understanding of social welfare. Policy differences shape the standard of living of long-term care residents and their families, the distribution of costs, and the burden of care.

Models of Funding for Long-Term Residential Care There are several models for financing long-term residential care. At one extreme, the state covers all costs (as in acute care hospitals). At the other extreme, residents incur the full costs, perhaps subsidized by charitable organizations. In between are models in which costs are shared between individuals and the state. Overlaid on these financing options are service delivery options ranging from for-profit and not-for-profit, to public providers. These options are not unique to the long-term residential care sector. The welfare state literature identifies various models for providing welfare services, which are characterized by different mixes of state, market, family, and community responsibility. The literature emphasizes patterns across countries and trends over time. One widely used typology (Esping-Andersen, 1990) distinguishes among liberal (typified by the United States), social democratic (Nordic), conservative/corporatist, and family-based (Mediterranean) regimes.[3] In most such typologies, Canada represents a mixed case. While much of our health care system is socialized, our social welfare needs are met through a mix of family, market, community, and state services, largely conforming to Esping-Andersen's liberal state grouping. This distinction in how health and social care needs are addressed exists in other countries, such as the United Kingdom.[4]

Jurisdictions differ on whether the long-term care sector is grouped with health services or with community and social services, or indeed if it is divided between the two. In OECD countries, some programs are based in the health system (Belgium) while others are separate (including programs funded out of general taxes, as in Nordic countries, and those funded at least partially through dedicated social insurance programs to which individuals contribute, as in Germany, the Netherlands, and Japan).[5] Historically in Canada, the long-term residential care sector evolved more as a social service than as a health service. Elderly people were cared for by family members for the most part, or in private facilities, or they were looked after by charities (or sometimes municipalities) in poorhouses designed to serve various indigent groups and not just the elderly.

In more recent years in Canada, the state has become more involved in both regulating and funding the long-term residential care sector. Initially,

public funding was provided through grants to charitable organizations to help keep the costs to residents low. When the subsidization of individuals became common, it was structured on a means-tested welfare model. When Medicare was introduced in Canada, the long-term residential care sector was not included. Later, the case was made that because the long-term residential care sector offers many of the same health care services as acute care, those costs should be covered by the state. However, the definition of "care" remains contested. Funding for the long-term residential care sector in Canada has evolved into a mixed model in which some costs are socialized and others remain privatized. Although this paper focuses on public/private funding, it should be noted that the provision of services is largely private (a category that includes for-profit and not-for-profit organizations).

Reimat analyzes the correspondence between the overall welfare regime, drawing on Esping-Andersen, and the model of long-term care in European countries, and finds in general a positive correspondence in the countries traditionally associated with the four regimes.[6] Daatland applies a similar framework of European social service provision to long-term care: a public service model where the state's role is primary (Norway); a means-tested model where the state's role is residual (United Kingdom); an insurance-based model (Germany); and a family care model (Spain).[7] This typology emphasizes differences in the role of the state, eligibility (universal vs. means tested), and the mode of financing. Gleckman uses five country examples to illustrate the range of financing options, including the role of resident copayments. One approach is to fund a long-term care insurance system through a payroll tax, with entitlements to either services or cash benefits, as in Germany.[8] Such a system provides universal benefits based on need, though the tax contributions are based on income. The Netherlands also has a dedicated insurance program funded through income-based tax premiums (managed by private insurance companies), as well as means-tested copayments by beneficiaries.[9] Japan funds long-term care through a payroll tax for those of working age combined with a premium paid by seniors, as well as funding from general revenues. Beneficiaries are charged a 10 percent copayment for services, and residents of nursing homes are charged $300 per month.[10] Both Germany and Japan have standard copayments across the country.[11] France funds long-

term care out of general revenues. Residential care is part of the health system, and income-tested cash benefits are used to cover other services. Although it is administered regionally, the benefit structure is standardized.[12] The United Kingdom separates health care and social care, providing the latter at the local level with uneven benefits and copayments. Copayments are based on assets as well as income.[13] In each of these cases, funds are raised through income-related measures, whether general tax revenue, payroll taxes, or insurance premiums. Most also apply a targeted universal model to beneficiaries in terms of income-related copayments. Finally, although there may be regional/local differences in service delivery, fees are typically determined at the national level. By way of comparison, Canada funds the long-term residential care sector from general revenues, with means-tested copayments (fees) and regionalization of both services and fees.

An OECD study of the provision and financing of long-term care proposes three broad country clusters based on a mix of the scope of entitlement (universal or means-tested) and whether the long-term residential care sector is a single system or a patchwork of programs. These country clusters are, first, universal coverage within a single program; second, mixed systems; and third, means-tested safety-net schemes.[14] The first group includes those in the Scandinavian model (described above) and those following the insurance-based corporatist model (used in the Netherlands, Germany, and Japan), while the third group tends to include countries associated with the liberal welfare regime (United States and United Kingdom). The study differentiates further according to whether the funding comes from general revenues or earmarked taxes/contributions. The study notes that long-term care coverage is somewhat of a latecomer in welfare systems; hence there is more fragmentation than exists in other program areas such as health care.[15] The comprehensiveness of long-term care coverage (including breadth of services, eligibility restrictions, and extent of private contributions) varies significantly within the broad groupings, including in the so-called universal programs.

Of particular relevance to this paper is the fact that all public long-term residential care systems in the OECD require some cost sharing by residents ranging from flat cost sharing (a fixed percentage of costs, common in social insurance schemes), to copayments as a percentage of disposable income/

assets (to a maximum), to a residual payment for the difference between total costs and public funding.[16] In particular, accommodation costs for institutional care are usually means tested. Public funding for this component may be available only for eligible poor, either as part of an overall means-tested long-term care program (such as Medicaid in the United States) or under social assistance; or it may be cost shared based on income tests or income/asset tests.[17] The OECD categorizes Canada as using income and/or asset-tested cost sharing. Note that this approach also applies to countries whose overall systems are described as "universal" (such as Nordic countries and the Netherlands). In other words, despite significant differences among overall program philosophies and designs, copayments for room and board based on ability to pay are widely accepted. The underlying argument is that a long-term residential care facility is a principal residence, and people are normally expected to pay for their primary room and board. As discussed below, this argument breaks down when there is a spouse left in the community.

While the principle of resident charges for accommodation costs may be widely accepted, there is considerable debate about how to measure ability to pay and at what level to set the copayments. Some people defend including assets as the best measure of overall net worth, but this can be perceived as unduly harsh (especially regarding the family home) and is more complex administratively. Options that are less punitive and have simpler administration include using an asset cut-off level or focusing on only liquid assets. However, given the correlation between income and net worth, there is an argument for using income alone. The interaction with the public pension system is also important. Seniors' ability to pay depends to a large extent on the comprehensiveness of the pension system.[18] In Canada, this means that a significant share of "private" contributions at the provincial level are in fact "public" contributions from the federal level. Historically, charging the elderly for the full costs of long-term residential care was defended based on the ability of the public pension system to cover these costs, and today minimum payments are typically pegged to the Old Age Security/Guaranteed Income Supplement (OAS/GIS).[19]

The OECD identifies a trend towards "targeted universality," as is common

across social security programs. Although coverage is universal, access and conditions of public support are targeted. One method of targeting is limiting eligibility based on need or age. Canada's publicly funded long-term care programs tend to be single-entry systems in which eligibility is based on a needs assessment, with formal provisions for managing the wait list. The trend is that eligibility for long-term residential care is increasingly restricted to higher levels of frailty.[20] Targeting can also be achieved through the basket of services covered. Finally, targeting can be achieved through cost-sharing mechanisms. In examining the resident charge structures across Canada, differences in both the fee structure and the service basket are important. A related issue is the question of providing benefits in the form of services or cash, with a trend towards using cash or voucher transfers.[21]

The literature attends to the economic incentives for users and providers created by various funding models, with cost containment, sustainability, and efficiency of prime concern.[22] Implications for quality have also received some attention.[23] Less attention has been paid to equity, though the OECD study argues that there are both fairness and efficiency grounds for universal long-term care coverage with targetting within such programs. Cost sharing is variously defended in terms of the risk of moral hazard, containing costs, and taking account of people's ability to pay.

Commonalities and Differences in Provincial Long-Term Residential Care Funding What principles govern the provision of long-term residential care in Canada? The *Canada Health Act* outlines five principles for health services: publicly administered (non-profit); comprehensive; universal; portable; and accessible. While no such legislation exists for long-term residential care, consensus has emerged in Canada about some common principles regarding funding[24]: health care costs are covered by the state; residents bear some responsibility for accommodation costs; public subsidization of accommodation costs is targetted based on ability to pay; resident payments should not take all of an individual's income; and resident payments should take into account the needs of other family members. There are many choices to be made in implementing each principle. The variation in resident charges observed across Canada reflects these choices.

Health Care Costs Are Covered by the State All provinces fund the "care" component of costs. Funding comes from federal transfers, via the Canada Health Transfer (CHT), and general provincial revenues including other federal transfers, such as equalization payments. But what is considered "care"? For example, in Prince Edward Island, items such as eyeglasses, hearing aids, dental services, ambulance services, and physiotherapy are described as "personal items" and are charged to the resident, while Alberta funds ambulance services as part of "health," and Quebec and Manitoba cover prescription drugs. Most jurisdictions include occupational and physical therapy in the "care" services funded in long-term residential care, but they do not directly cover dental, vision, or hearing. Care services that are available to seniors in their homes may also be available to long-term care residents, as in New Brunswick, where the Extra-Mural Program funds services such as physiotherapy to assessed clients regardless of where they live.

Individuals Bear Some Responsibility for Accommodation Costs As noted above, residents are generally expected to contribute to their accommodation costs. Only Nunavut does not charge residents. In most jurisdictions, the rationale for fees is that residents would incur accommodation costs if they were in the community. Nursing homes are conceived as primary residences, unlike acute care, which is by definition short term. As noted above, this idea of the facility as "home" is also used to explain why some health-related therapies and medications that would be provided in a hospital are the financial responsibility of the long-term care resident. The fees charged for long-term residential care may be based on full responsibility for room and board costs, or they may represent a contribution towards those costs (shared responsibility).

Only Ontario, Alberta, and Quebec charge for different room types. Manitoba allows a $2.50/day surcharge for a semiprivate room, and $5 for a private room only if the client requests it. In contrast, most provinces leave room placement to the discretion of facilities for the purpose of managing care needs.

Provinces and territories differ on the level of the "standard" (sometimes called "maximum") rate, and in most provinces long-term care homes cannot charge more than the stated standard fee. Three provinces charge more than

$100/day, which is argued to be the full cost of the room and board. In Nova Scotia it is an average residual after health and professional service costs (covered by the Department of Health and Wellness) are deducted. Other jurisdictions make a less direct link to actual accommodation costs. Only Manitoba and the Yukon do not describe the resident fee specifically in terms of a contribution to "accommodation" costs or "room and board." The territories, Quebec, and Alberta have the lowest standard rates, while the remaining provinces charge from $56 to $92 per day. The standard rate in Quebec is one third that of Nova Scotia, which is unlikely to reflect differences in actual accommodation costs.

The relationship of fees to actual accommodation costs varies, and seems to depend in part on the historical evolution of long-term residential care in the jurisdiction. In the Maritime provinces, for example, residents paid the full cost of long-term residential care until relatively recently. When these provinces agreed to take over the health care costs, calculations were made to determine what to include in the category of "health." Residents were then charged for the remaining "accommodation costs." In Nova Scotia, this is calculated annually, whereas in Prince Edward Island and New Brunswick the fee was set in this way when the provinces first instituted a standard fee and/or took over funding health care costs in the facilities. Since then, the rates have increased based on negotiation (in Prince Edward Island), based on increases in the consumer price index (CPI), or increases in OAS/GIS. In contrast, historically the Yukon financed most of long-term residential care publicly, with residents contributing only a small amount. In 2013, the Yukon increased the rates (and standardized them) to $35/day. In the Northwest Territories, the resident rate is understood to be a nominal charge, despite language that it is for "room and board."

Alberta (with one of the lowest rates) is now trying to calculate actual accommodation costs. The grey areas of this costing were pointed out in an interview with an Alberta Health official. For example, how should one allocate administrative costs such as accounting? Are utility and maintenance costs purely "accommodation"? It was also pointed out that provinces and territories may differ in which costs they fund (for example, depreciation or property taxes), and operators may manipulate how they allocate costs across categories. Calculating "accommodation" costs is thus an

imperfect science, which may explain some of the variation in rates.

Provinces also differ in terms of which supplies/services are covered by these "accommodation" fees and which additional costs are billed to residents. In 2012, Saskatchewan introduced a $20 monthly fee for "personal hygiene" items. Incontinence supplies are usually included, but not in Saskatchewan and the Northwest Territories. Personal laundry is included, except in Alberta.

Financial Support for Accommodation Costs Is Targetted Based on Ability to Pay This principle is in keeping with a social care model, with the state being the payer of last resort. Just as individuals who cannot support themselves are entitled to social assistance, so individuals who cannot afford the full living costs in long-term residential care are entitled to subsidies, with variation in how the copayment is construed (with the exception of Nunavut, which covers the full cost). The Yukon and Northwest Territories have low flat fees ($35/day and $24.72/day), with support available through social assistance. Alberta also has a set fee, with an "accommodation benefit" for long-term residential care available as part of the Alberta Seniors Benefit (ASB). In the remaining provinces, fees are subsidized through the relevant department. In Ontario, unlike all other jurisdictions, only shared rooms are eligible for income-based fee assessments. Throughout Canada, residents are expected to apply for all available state income benefits (for example, OAS/GIS, provincial senior benefits, and disability benefits) before fee reductions are granted. The state (department of health, typically) is the payer of last resort in all jurisdictions.

Assessing ability to pay requires income and/or asset testing. Provinces differ in whether they assess gross income (Saskatchewan, Alberta, and Quebec), net income (Prince Edward Island and Newfoundland and Labrador), or after-tax income (Ontario, British Columbia, Nova Scotia, Manitoba, and New Brunswick) and what deductions are allowed from income (for example, Veterans' disability pensions). They also differ in terms of whether assets are included (Quebec). Newfoundland and Labrador uses a liquid asset cut-off—one must have less than $10,000 (single) or $20,000 (couple) in liquid assets to be eligible for a subsidy, which is then income-based. Nova Scotia and Prince Edward Island dropped asset testing in 2005 and 2007.

There is agreement with the principle that the minimum payment required should be affordable for those with only state-provided benefits (for example, OAS/GIS) and that the charge should increase with income. Some provinces (British Columbia, Manitoba, and Saskatchewan) have a formal minimum required contribution, which is pegged to OAS/GIS. There are various ways to structure an income-based payment scale. In several provinces the resident charge increases dollar for dollar (100 percent effective marginal tax rate on income above the minimum, up to the income threshold for paying the standard rate). In other provinces, the fee increases by less than the increase in income—Saskatchewan uses 50 percent and New Brunswick has a scale when a spouse is present).

Provinces differ in how the fees are described, reflecting differences in the underlying philosophy of responsibility and cost sharing. Ontario uses the term "co-payment," while Nova Scotia uses the term "standard accommodation charge" to denote the charge that residents are expected to pay unless they apply for a lower rate based on an income assessment. Some provinces (New Brunswick, Alberta, Newfoundland and Labrador, and Quebec) use the term "maximum" charge for this normal fee. The lower rate is variously described as a "subsidy"' (Prince Edward Island, New Brunswick, and Newfoundland and Labrador) or as a "rate reduction" (Ontario), or "reduced contribution" (Quebec). In these provinces, the clear message is that the individual/family is responsible for the accommodation costs, with fee reductions being the exception for poorer people. One must apply for a reduced fee, whereas in Manitoba, Saskatchewan, and British Columbia there are clear income-based fee schedules (with minimum and maximum fees), which are applied to each resident unless one opts not to submit income information. In these provinces, an income assessment is a normal part of the application process. The descriptions in these provinces imply that income-based fee differentials are a central feature of the program and apply to everyone. The maximum charge is not portrayed as standard; indeed, Saskatchewan uses the term "standard" rate to denote the minimum rate, with contributions rising with income.

Alberta describes a maximum fee, with "financial assistance" for low-income residents. However, there is no direct income assessment for long-term residential care. This financial support is integrated into the ASB,

with benefit amounts based on a mix of income, marital status, and accommodation (living in long-term residential care or in the community), and levels are set so the ASB keeps pace with increases in long-term residential care fees. In this case the income assessment is at arm's length from the long-term residential care program.

Resident Payments Should Not Take All of an Individual's Disposable Income There is agreement that residents should be left with some discretionary income. All provinces allow a spending allowance for those who are subsidized. This is described variously as a comfort allowance, personal care allowance, minimum retained income, or client disposable income. Some provinces (Newfoundland and Labrador, Ontario, Manitoba, Quebec, Prince Edward island, New Brunswick, and Alberta) have a fixed dollar value for minimum retained income or comfort allowance, while others (Nova Scotia, Saskatchewan, and British Columbia) allow the residents to retain a percentage of their income above the minimum (up to a maximum in Saskatchewan). A fixed deduction makes the resulting fee more progressive in relation to income; those with a higher income in effect pay a higher percentage of their income. Several provinces have provisions (hardship waivers) for adjusting the assessed payments to take account of particular situations where income needs are higher (e.g., exceptional drug costs).

Resident Payments Should Take Into Account the Needs of Other Family Members There is agreement that fees should be structured to take into account the needs of spouses or other dependants. This raises several issues in terms of implementation of the principle. First, how is income to be measured? Ontario and British Columbia use individual income, while Nova Scotia, Manitoba, Quebec, Saskatchewan, Prince Edward Island, and New Brunswick use combined income of spouses to assess charges. Alberta also uses combined income to assess eligibility for the ASB. If combined income is used, how is it divided? In most provinces, income is divided 50/50, but Nova Scotia recently introduced a 60/40 split to help the spouse in the community. Several provinces (Nova Scotia, Manitoba, Quebec, New Brunswick, Newfoundland and Labrador, and Ontario) also have an explicit

minimum retained income for a spouse (and other dependants) in the payment formula, while other provinces note that the needs of the spouse will be taken into account. In some provinces (Nova Scotia, Ontario, and Quebec), the minimum retained income for a spouse is a flat amount, ranging from $13,590/year in Quebec to $20,180/year in Nova Scotia. New Brunswick has a scale, and Manitoba allows a (flat) higher amount for those who pay more than the minimum fee, allowing higher-income people to retain more income. In Alberta, the ASB formula includes a cash benefit for the spouse. Four provinces (Prince Edward Island, New Brunswick, Manitoba, and British Columbia) also have explicit financial hardship policy statements, allowing for a full or partial waiver of a nursing home fee if fee payment prevents the spouse or family in the community from being able to purchase basic necessities (rent, utilities, food, medicine, and health care services). As noted, when there is a spouse in the community, the rationale for accommodation costs (as the primary residence) breaks down.

Other Relevant Jurisdictional Differences Comparisons of long-term residential care are complicated by other institutional differences across jurisdictions. Programs for drug coverage and extended health benefits for noninsured items affect the "care" services available to long-term care residents. These are primarily available only to seniors, so younger adults in long-term residential care incur more out-of-pocket costs. As well, provinces and territories offer a range of income benefits that affect the fee structures (such as the Ontario Disability Support Program and many provincial and territorial supplementary income benefit programs for seniors). Jurisdictions also differ in their tax structures and rates. Another complication in comparing programs is that the provinces and territories adjust their fee schedules at different times—most do so annually, but Newfoundland and Labrador, Prince Edward Island, Alberta, the Yukon, and the Northwest Territories change fees sporadically, while Saskatchewan changes quarterly. Any date chosen for comparison will result in some provinces and territories whose rates are soon to go up, and others whose rates have just increased. This study uses rates as of 1 January 2014.

Table 1 summarizes the basic program parameters in each province, as well as the calculated income threshold at which residents pay the standard

Table 1. Summary of Formulas for Calculating Resident Fees

	Standard rate/day (minimum rate)	**Income (assets) used in calculation ***	**Minimum retained income/year (resident) ****	**Income assessed with spouse**	**Minimum retained income/year for spouse in community*****	**Calculated income threshold for paying the standard rate, Single (married, spouse in community) *******
NL	$92.05	Net income liquid asset cut-off ($10,000 single, $20,000 couple)	$1,800 ($150/month) Subsidized only	Combined income	$10,800 ($900/month)	Liquid assets >$10,000, or $35,400 ($46,198)
PE	$77.60**	Net income	$1,236 ($103/month) subsidized only	50% of combined income	Allow "min. standard of living." Normally OAS/GIS ($15,546)	$29,560 ($59,120)
NS	$104	After-tax income	Greater of $3,072 ($256/month) or 15% of income	40% of combined income	$20,180 ($1681.67/mo nth)	$44,659 ($111,647)
NB	$107	After-tax income	$1,296 ($108/month)	Combined income (split 50/50 only if both are in long-term residential care)	OAS/GIS (single) $15,546 plus scale above that	$40,351 ($65,624)
QC	$35.92 (basic) $48.84 (semi) $56.28	Most assets, plus gross income	$2,436 ($203/month)	Combined income	$13,590 ($1132.48/mo nth)	$15,547 basic to $31,488 for private ($29,137 basic)

	Standard rate/day (minimum rate)	**Income (assets) used in calculation ***	**Minimum retained income/year (resident) ****	**Income assessed with spouse**	**Minimum retained income/year for spouse in community*** **	**Calculated income threshold for paying the standard rate, Single (married, spouse in community) ********
	(private)					
ON	$56.14 (basic) $64.14-66.14 (semi) $74.14-77.64 (private)	After-tax income	$1,632 ($136/month)	Individual income	OAS/GIS	$22,123 basic room ($36,037)
MB	$79.20 ($33.90)	After-tax income	$3,600 ($300/month)	Combined income	$15,986 (or $32,772 if pay above min.)	$32,508 ($65,280)
SK	$64.04 ($33.93)	Gross income	$3,456 ($288/month) at minimum income, plus 50% of income >$1320 and <$3184/month	50% of combined income (or can opt for individual income if spouse not in long-term residential care)	no	$38,208 ($76,416)
AB	$48.15 (basic) $50.80 (semi) $58.70 (private)	Gross income (assessed for ASB)	$3,180 ($265/month)	50% of combined income	"Reasonable income"	$25,800***** ($41,900)

	Standard rate/day (minimum rate)	Income (assets) used in calculation *	Minimum retained income/year (resident) **	Income assessed with spouse	Minimum retained income/year for spouse in community***	Calculated income threshold for paying the standard rate, Single (married, spouse in community) ****
BC	$101.67* ($31.91)	After-tax income	Greater of $3,900 ($325/month) or 20% of income	Individual income	No	$46,389 (same)
YT	$35	No assessment	No		No	NA
NT	$24.72	Can apply for income assistance	No		No	NA
NU	NA	No charge	NA		NA	NA

Notes: These formulas apply to all room types except in Ontario (ON), where only basic shared rooms (2+beds) are eligible for subsidy. In Quebec (QC), subsidies vary by room type. In the territories, there is either no charge (Nunavut (NU)) or a flat rate (Yukon (YT) and Northwest Territories (NT)).

* Most provinces allow some types of income to be deducted, such as Veterans' pension or one-time benefit payouts. These have not been factored in.

** Various terms: Minimum retained income (Nova Scotia); "personal care allowance" (Newfoundland and Labrador (NL)); "comfort allowance" (Prince Edward Island (PE), ON); "client disposable income" (Manitoba (MB)); "comfort and clothing allowance" (New Brunswick (NB)); allowance for "personal expenses" (QC); "disposable income" (AB).

*** Particulars of spousal deductions: ON—no dependant deduction if spouse gets OAS/GIS; otherwise the dependant deduction is OAS/GIS—dependant annual net income (after tax); NB—keep 20% of income between OAS/GIS and twice that; plus keep 70% of income between twice OAS/GIS and (OAS/GIS + $25,000); keep all income over this amount. Used OAS/GIS for July–September 2013.

**** The threshold income for a spouse in the community is combined income, except in ON and British Columbia (BC), where individual incomes are used. The BC formula is the same for single or married people, hence the same income threshold.

***** These are the income thresholds to receive the Alberta Seniors Benefit.

rate (maximum rate). It is clear that the Quebec and Alberta rates are kept low (flat rates, set so that those relying on government income transfers can pay), while Nova Scotia, Newfoundland and Labrador, New Brunswick, and British Columbia charge more of a market rate for those who can afford it, with targetted subsidies.

Equity Implications of Residence Fees Three types of equity are of interest: differences in payments across provinces and territories for similar income (horizontal equity); differences within provinces and territories by income (vertical equity); and gender equity. While there is no mandate in Canada for equity of fees across jurisdictions, the extent of the discrepancies is important. Vertical equity within jurisdictions can be understood in various ways. Universal, publicly financed long-term residential care, regardless of income, is equitable in that everyone is treated the same. A low flat fee set at a level that is affordable with public pensions, as in the Yukon, also treats everyone the same, although flat fees are regressive as a percentage of income. The principle of assessing fees based on ability to pay, as adopted in most Canadian jurisdictions, represents another notion of vertical equity (equal "pain"). Here the range of fees and the percentage of income paid are relevant. In terms of gender equity, some key issues include how income is allocated between spouses, how the nonresident spouse's needs are addressed, and whether there are gender differences in the cost of long-term residential care relative to income. Simple scenarios illuminate these questions.

Long-Term Residential Care Fee Scenarios for Unattached Individuals
The income thresholds above which residents pay the full daily rate (see Table 1 column 6) vary considerably, reflecting differences in both standard rates and minimum retained income. While British Columbia, Nova Scotia, and New Brunswick have similar standard rates, New Brunswick residents pay it at a significantly lower income level. Prince Edward Island and Manitoba have comparable standard rates, but in Prince Edward Island it is paid at a lower income level. Quebec has the lowest standard rate and the lowest income threshold (with the proviso that assets are assessed).

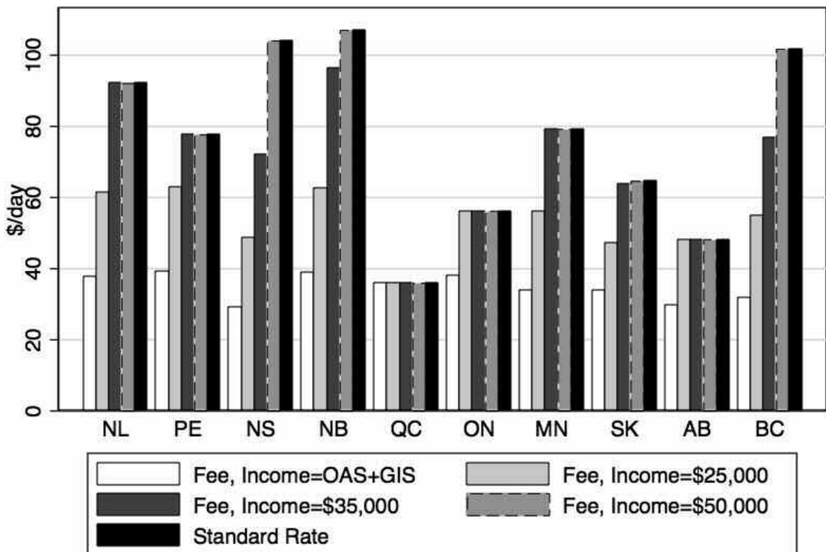
In order to further compare the costs residents incur for long-term residential care across jurisdictions, the Survey of Labour and Income Dynamics (SLID) was used to estimate daily fees under various income and family assumptions, using the detailed fee formulas for each province (territories do not assess income), beginning with resident fees for unmarried seniors with various levels of prespecified after-tax income (calculated for basic shared rooms for the three provinces that make that distinction). Because provinces use different definitions of income, it was necessary to convert these incomes to corresponding definitions of assessed incomes before calculating resident fees. The calculated fees reported below represent the effect of provincial differences in fee formulas (including minimum retained incomes).

Data were obtained from the SLID for the survey years 2009 and 2010. The sample was restricted to individuals aged 65 and older who reported no earnings. All incomes were adjusted to 2013 dollars using the all-items CPI prior to calculating resident fees. The SLID reports gross and after-tax incomes for individual respondents and their spouses. Moreover, the public-use SLID files contain certain tax deduction variables, which we used to approximate net income and net income after taxes. These four definitions fully capture the various income definitions used throughout Canada to calculate long-term residential care fees.[25]

Figure 1 shows resident fees for unmarried seniors by fixed levels of after-tax income (only OAS+GIS; $25,000; $35,000; and $50,000; tables available by request). In terms of equity across provinces, the fees vary less at lower levels of income (OAS+GIS and $25,000), similar to the findings of Fernandes and Spencer using 2008 rates and a different methodology.[26] The highest fee is 1.35 times the lowest with only OAS+GIS (highest fee is Prince Edward Island at $39.21day; lowest fee is Nova Scotia at $29.05/day) and 1.75 times the lowest at incomes of $25,000 (highest fee is Prince Edward Island at $62.87/day; lowest fee is Quebec at $35.92). By contrast, the highest fee (New Brunswick) is three times as much as the lowest (Quebec) for the highest income category ($50,000); all are paying the standard daily rate. Much of this difference is explained by the fact that Quebec offers a relatively low standard rate ($35.92). If we compare Manitoba and Saskatchewan, the difference in fees is negligible with income equal to

OAS+GIS, but almost $15/day with an income of $50,000/year. At $25,000/year, fees are still subsidized (that is, lower than standard rates) in all provinces except Quebec, Alberta, and Ontario, while at $35,000/year most provinces charge full rates. New Brunswick and Newfoundland and Labrador are the most expensive for those with incomes of $35,000, while Nova Scotia and New Brunswick are the most expensive for those with incomes of $50,000. One limitation of this comparison is that the rate used for Ontario, Quebec, and Alberta is for a basic shared room, whereas in the other provinces the room could be shared or private. Private and semiprivate rooms are not subsidized in Ontario, so residents in such rooms would pay the standard rate of $64–$74 regardless of income, comparable to standard rates in Manitoba, Saskatchewan, and Prince Edward Island (moderate). In Quebec and Alberta, private room rates ($56.28 and $58.70,

Figure 1 Daily fees at different levels of after-tax income: Unmarried seniors



Notes: After-tax income is converted to gross, net, or net after-tax income based on each province's definition of "assessed" income. Conversion factors were derived from the 2009 and 2010 Surveys of Labour and Income Dynamics (SLID) using recorded variables for gross income and after-tax income, and using derived measures of net income and net income after taxes. Conversion factors use incomes for all single non-earner seniors living in one of the 10 Canadian provinces.

OAS/GIS is for July–September 2013 ($15,546).

Standard rate corresponds to the rate for a basic room in QC, ON, and AB (e.g., 3+ beds).

respectively) are lower than standard rates in all other provinces, and are comparable to fees paid by residents with incomes of only $25,000 in most other provinces.

In terms of variation by income within provinces, those provinces that keep their rates low are by definition more regressive—higher income earners pay a lower percent of their income. In provinces with higher standard rates, the key factor affecting how fees vary with income is the formula for minimum retained income. Seven provinces impose an effective 100 percent marginal tax rate on income between the minimum (approximately maximum OAS+GIS) and the threshold at which the standard rate is paid, as the "comfort allowance" is a flat amount. Nova Scotia has an effective tax rate of 85 percent beyond the minimum income level, while British Columbia's is 80 percent. Saskatchewan has the lowest, at 50 percent (see Table 1). Not only might this "tax rate" affect income or savings incentives (in theory, though perhaps not in practice, with an elderly population), it affects the rate at which one moves towards paying the full standard rate (equity). Comparing Newfoundland and Labrador, Nova Scotia, New Brunswick, and British Columbia (high standard rates), we see that individual fees rise more dramatically in New Brunswick and Newfoundland and Labrador, given low flat retained incomes rather than the proportional retained income formulas in Nova Scotia and British Columbia. In the provinces with the lowest standard rates (Quebec, Alberta, and Ontario for basic rooms), the full rate applies at all three income levels above OAS+GIS.[27] In provinces with mid-range standard rates (Prince Edward Island, Manitoba, and Saskatchewan), residents in the top two income levels pay the full rate. Note that as daily rates go up, without a change in the allowed share of retained income, payments increase more for those at higher incomes.

These scenarios used common income levels to examine differences across provinces in long-term residential care payments. The scenarios in Table 2 take account of provincial differences in incomes, using SLID data on male and female median incomes of unattached seniors. Note that the female-male income ratio for seniors is quite high (due to OAS+GIS) compared to the female-male earnings ratio (72 percent in 2011; Cansim 202-0104). Indeed, in Newfoundland and Labrador, Prince Edward Island, and Manitoba,

Table 2. Calculated Resident Fees* Based on After-Tax Median Incomes, Unmarried Non-Earner Seniors

	Median Female Income**	Female Fee/day	Share of Median Income	Median Male Income**	Male Fee/day	Share of Median Income
	$	$	%	$	$	%
NL	20,449	48.13	85.9	20,423	47.92	85.6
PE	19,632	49.11	91.3	17,893	45.06	91.9
NS	20,959	39.53	68.8	21,012	39.55	68.7
NB	19,869	49.08	90.2	24,386	63.09	94.4
QC	20,476	35.92	64.0	22,381	35.92	58.6
ON	23,964	56.14	85.5	33,857	56.14	60.5
MB	24,997	54.97	80.3	22,478	49.10	79.7
SK	22,057	41.68	69.0	26,165	47.90	66.8
AB	25,655	48.15	68.0	25,825	48.15	68.1
BC	20,127	44.11	80.0	27,970	61.30	80.0

Source: Survey of Labour and Income Dynamics (2009 and 2010).

* Resident fees are calculated based on median incomes. Median incomes and resident costs are calculated for each sex-province cell. In ON, QC, and AB, the fee is for a basic room.

** Incomes reported for 2009 and 2010 were adjusted to 2013 dollars using the all-items Consumer Price Index prior to imputing resident fees, which, in 2014, would be assessed on income earned in the 2013 tax year.

median incomes of senior females are slightly higher than those for males. Daily long-term residential care fees were calculated for the relevant median income (by province and sex). Only in Quebec, Ontario, and Alberta do residents (males) with median income pay the standard rate (for basic rooms in these provinces). Estimated daily fees range from $35.92 to $56.14 for women and from $35.92 to $63.09 for men.

Across provinces, there is little relationship between the rankings on median income and the rankings on daily fees paid at that income level. Note that although Nova Scotia has the highest standard rate, a woman of median income pays less than a comparable person in any other province except Quebec. Annualized fees represent 64 to 91 percent of median income for women and 58 to 94 percent for men. The percent of income paid in Prince Edward Island and New Brunswick is particularly high (male and female).

What are the gender equity implications? Women generally pay lower fees, given their lower incomes. However, the rate at which the fees increase

(the formula for retained income) and the level of the standard rate affect the percentage of income paid. In the provinces with the lowest standard rates (Ontario, Alberta, and Quebec for basic shared rooms), men and women of median income pay the same fees, with these typically representing a higher share of income for women (Ontario and Quebec). Note that in Ontario, for a private or semiprivate room men and women would each pay the standard rate ($74.14 or $64.14), which is more expensive than the rate of any other province and represents a higher share of women's than men's median income. In provinces with low retained incomes (Ontario, Prince Edward Island, Newfoundland and Labrador, and New Brunswick), women on average pay a higher percentage of their incomes than men. The share of median income represented by the long-term residential care fees is quite comparable for men and women in provinces with high or proportional retained incomes (Nova Scotia, British Columbia, Manitoba, and Saskatchewan).

Long-Term Residential Care Cost Scenarios for Married Residents

Provinces differ in how resident costs are calculated for couples. The principal considerations are how to assess incomes (individual or combined), how to divide combined income between spouses, and how to set the fee structure, taking account of the needs of both spouses. First, one has to decide how to allocate family income between the two spouses to determine ability to pay. Second, the subsidization formula has to be adjusted. When both spouses are in care, the main issue is that the lower limit of payment is typically pegged to maximum single OAS+GIS, while OAS+GIS for a couple is less, so they would not be able to afford even the minimum fee. A third consideration, when there is a spouse left in the community, is whether/how to ensure adequate income for that person. Stadnyk found that the financial stress on a community spouse was stronger in the provinces with the higher fees (Nova Scotia for example, which also assessed assets at the time of this study) than in those with a flatter rate structure (Alberta) or those with a sliding income-based scale (Manitoba), which has become the most common structure.[28] Unlike the situation of a single person, where the facility is the primary residence, a second residence must be maintained for

the community spouse. Various approaches have emerged for how to leave adequate financial resources for the spouse in the community, while still applying the principle that "accommodation costs" are the responsibility of the individual/family. Equity issues include how the married person is treated compared to the single person; interprovincial comparisons for what couples in similar income situations pay (and retain); and comparisons within provinces by income for what couples pay (and retain).

In general, Canadian policy is mixed in terms of how to treat family income. Income tax is paid on individual income, though many credits are based on combined income, and splitting of pension income has been allowed since 2006. The feminist economics literature favours individual taxation and entitlements, given the negative work incentives created by joint taxation (not relevant for retired seniors). Marital property laws, on the other hand, are based on the principle of equal rights to joint assets.

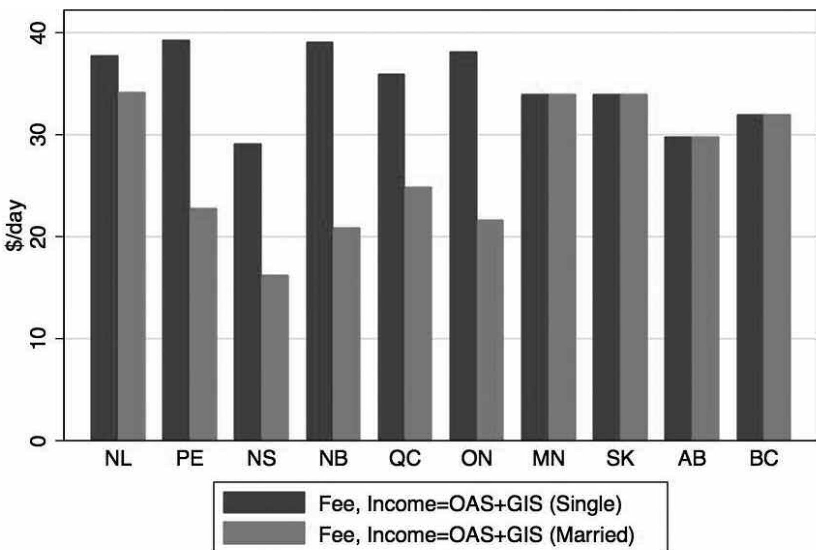
As noted earlier, two provinces (Ontario and British Columbia) base the long-term residential care assessment of ability to pay on individual income. In this case, if both individuals were in long-term residential care, the lower-income spouse would pay less than the higher-income spouse. If only one spouse were in care, it would matter which one—the higher-income spouse would pay more, leaving less for the community spouse than vice versa. If wives tend to have lower incomes and live longer, they would typically retain less income than a husband left in the community, though pension splitting helps to address this issue. The policy trend across the country has been towards using combined income in calculating long-term residential care fees. New Brunswick, Newfoundland and Labrador, Manitoba, and Quebec apply the fee formula directly to combined income; Alberta also assesses combined income for the ASB. The remaining provinces split the income before assessing fees (see Table 1). Income is split 50/50 in Prince Edward Island and Saskatchewan and 60/40 in Nova Scotia, which favours the spouse in the community. Splitting income is one way to protect income in order to support the spouse.

The charge formula might also take direct account of the income needs of the spouse in the community. Six provinces that combine income stipulate a minimum retained spousal income, usually at the level of OAS+GIS

for a single person. While this ensures a minimum income, it does not address the decline in income that would be experienced by a higher-income couple. Manitoba takes this into account by stipulating a spousal retained income amount ($32,772) for those who pay between the minimum charge and the standard rate (note that this is higher than the Manitoba average incomes of senior single men and women). Nova Scotia, Ontario, and Quebec have flat minimum retained incomes for spouses. The Nova Scotia minimum for the spouse (the highest, at $20,180) is still lower than the Nova Scotia median incomes of single seniors. New Brunswick uses a scale above a minimum. These are relatively recent innovations. In Ontario, which assesses individual income, the resident is allowed a deduction in assessed income of an amount to bring the spouse's income up to the level of the OAS+GIS. Some provinces say only that the spouse can retain a "reasonable income."

The calculated income threshold at which a person with a spouse in the community would pay the full long-term residential care rate is given in

Figure 2 Fee for LTRC with OAS/GIS only (both)



Notes: OAS/GIS is for July-September 2013 ($15,546 single; $25,063 married).
Standard rate corresponds to the rate for a basic room in QC, ON, and AB (e.g., 3+ beds)

Table 1 (column 6). In Nova Scotia, with its favourable income split, the threshold for paying the standard rate ($104) is $111,647, leaving $66,988 for the spouse. In New Brunswick in contrast, the income threshold for paying the daily maximum ($107) is $65,624. At this income level the spouse keeps only 40 percent of income compared to 60 percent in Nova Scotia. In Manitoba, the income threshold for paying the maximum rate is $65,280. Note that at this income level a married Nova Scotian would be paying $57.23/day, compared to $79.20 in Manitoba. In Saskatchewan, with no stated minimum retained income for a spouse, the income threshold for paying the standard rate ($64.04) is $76,416. In Alberta, the effective income threshold for paying a full daily rate is $41,900 gross (that is, not eligible for the ASB). At this income level, the community spouse retains 42 percent of income.

Figure 2 compares the fee for long-term residential care for a married person with a spouse in the community to that of a single person, when the only income is OAS+GIS ($25,063 for a couple and $15,546 for a single person in July–September 2013). In some provinces, the married resident pays the same standard minimum as a single person, while in other provinces the married fee is significantly lower, leaving more for the spouse. There is more inequity across provinces in fees for low-income married

Table 3. Median After-Tax Incomes, Married Non-Earner Seniors

	Combined Income ($)	Husband's Income ($)	Wife's Income ($)
NL	33,203	19,711	13,492
PE	38,626	24,939	13,686
NS	39,001	27,090	11,911
NB	34,242	23,079	11,164
QC	33,446	21,477	11,969
ON	42,615	24,179	18,436
MB	46,559	31,169	15,390
SK	54,538	28,397	26,141
AB	49,592	28,660	20,932
BC	32,251	18,812	13,439

Source: Survey of Labour and Income Dynamics (2009 and 2010).

Note: Incomes reported for 2009 and 2010 were adjusted to 2013 dollars using the all-items Consumer Price Index.

residents than for single residents.

Table 3 shows the median incomes of couples, while Table 4 gives calculated fees of couples with median income and one person in care, and percentage of income paid, which can be compared to Table 2 for single individuals. The married fees are lower than the standard rate, except in Alberta, Ontario, and Quebec. At the extremes, the daily fee for couples of median income (husband or wife in care) ranges from $26.84 in Nova Scotia to $64.12 in Prince Edward Island (with quite similar median incomes). Both the income split and the retained income specification matter in determining the effective share of income paid.

For those with median incomes, residents with a spouse in the community pay significantly less than single individuals in Nova Scotia, New Brunswick, and Manitoba because of generous allowances for spouses in the community. In British Columbia, which uses individual incomes, the married fees are lower because of lower incomes compared to singles. In Alberta, with its flat rate structure, both single and married individuals of median income pay the same (standard) rates, with resulting differences in the share of income paid. In general, the range of fees across provinces at median income is greater for married than single residents.[29]

In provinces that assess combined incomes (all except British Columbia and Ontario), fees are similar regardless of which spouse is admitted, though those fees represent a higher percentage of a wife's own income than a husband's (or indeed a single woman's on average). Note the striking difference in fees between Prince Edward Island and Nova Scotia (with similar median incomes), reflecting the combination of higher minimum retained income, favourable income split, and more generous allowance for a spouse in the community in Nova Scotia. The generous allowance in Manitoba for a spouse in the community also results in a low percentage of income paid in that province. Married residents of median income with a spouse in the community pay less than the standard rate in all provinces except Ontario, Quebec, and Alberta (where standard rates are relatively low).

Conclusion There are large discrepancies across Canada in long-term residential care rates and in what residents pay relative to income, reflecting

Table 4. Calculated Resident Fees* of Married Seniors, Based on Median After-Tax Incomes of Self and Couple, With One Spouse Living in the Community

	Fee/Day Husband Admitted	Share of Own Income**	Share of Combined Income**	Fee/Day Wife Admitted	Share of Own Income**	Share of Combined Income**
	$	%	%	$	%	%
NL	54.15	100.3	59.5	54.15	146.5	59.5
PE	64.12	93.8	60.6	64.12	171.0	60.6
NS	26.84	36.2	25.1	26.84	82.3	25.1
NB	35.27	55.8	37.6	35.27	115.3	37.6
QC	35.92	61.0	39.2	35.92	109.5	39.2
ON	56.14	84.7	48.1	45.52	90.1	39.0
MB	35.92	42.1	28.2	35.92	85.2	28.2
SK	51.15	65.7	34.2	51.00	71.2	34.1
AB	48.15	61.3	35.4	48.15	84.0	35.4
BC	40.85	79.3	46.2	31.19	84.7	35.3

Source: Survey of Labour and Income Dynamics (2009 and 2010).

*Resident fees are calculated for each sex-province cell based on median after-tax incomes. In ON, QC, and AB, the fee is for a basic room.

**Incomes reported for 2009 and 2010 were adjusted to 2013 dollars using the all-items Consumer Price Index prior to imputing fees (which, in 2014, would be assessed on income earned in the 2013 tax year).

different underlying models of entitlement and the extent to which income is targetted. Provinces and territories share the common principles that care costs are covered by the state while residents pay accommodation costs (except in Nunavut), subject to means-tested subsidies in most jurisdictions. Provinces and territories differ in how the means test is applied, such as income testing of all residents, income testing of only “needy” residents, income testing of all seniors outside of the long-term residential care system, and including assets. There are large differences in the standard rate, which ranges from $24.72–$107.00 per day, with provinces following one of three models: high fee covering full accommodation costs ($100/day range); mid-range fee ($50–$80/day); and low fee (less than $50/day). There are also different subsidy rates. In some provinces, subsidies are aimed mainly at people with lower incomes and the standard rate is reached at a relatively low income level. Other provinces provide decreasing subsidies over a wider range of incomes, that is, they allow for more retained income. For example, Nova Scotia and New Brunswick have similar standard rates, but the income

threshold at which it is paid varies dramatically because Nova Scotia allows a percentage of income to be retained, rather than a flat amount. Nova Scotia is one of the cheapest provinces for residents at a median income level, despite having the highest standard rate. In general, higher retained incomes keep long-term residential care more affordable for those with lower incomes, while using a percentage rather than a flat amount reduces the burden on higher-income individuals and families.

The fee structures also take different account of the needs of a spouse living in the community. Nova Scotia is quite generous across the income distribution, while New Brunswick is generous at lower income levels and Manitoba at median income levels. Both the income split and the formula for minimum retained income for the spouse matter. A percentage formula reduces the impact on higher-income families (perhaps allowing the spouse to keep the family home, for example). Generous spousal allowances are important for both the short-term and long-term financial well-being of the spouse.

These differences affect equity within provinces. A low flat fee (as exists in the Yukon, the Northwest Territories, Quebec, and Alberta) keeps long-term residential care affordable for most seniors. Although it is regressive in terms of the share of income paid, the tax system that funds it is progressive. Interestingly, the two low flat-rate provinces are at opposite ends of the spectrum in terms of welfare state analysis—Alberta is associated with a more limited view of the state's role and Quebec with a more Nordic model. There may be a trade-off between resident fees and supply of long-term residential care because both Alberta and Quebec were found to have relatively low numbers of beds per population 85 years and older.[30] A sliding scale model is less regressive and can be designed to be affordable at low incomes; however, it penalizes "savers" and is the furthest from a universal entitlement. Another point to consider in terms of equity is that, in most provinces, the standard rate is applied regardless of type of room (private or shared).

In terms of equity across provinces, fees are more equal at lower than higher incomes, and they are more equal for single residents than married ones. Nova Scotia is the cheapest for single and married residents with only OAS/GIS. For single residents, New Brunswick and Newfoundland and

Labrador are the most expensive at $35,000 because of high standard rates and low minimum retained incomes. At $50,000, long-term residential care is considerably cheaper in Alberta, Quebec, Saskatchewan, and Ontario than it is in Nova Scotia, New Brunswick, British Columbia, and Newfoundland and Labrador. At the standard rate, a person in a shared room in New Brunswick pays three times what one pays in Quebec. There is no systematic relationship between rates and incomes across provinces at median income levels.

In terms of gender equity, long-term residential care fees are lower for single senior women than men in most provinces because of the women's lower average incomes. However, the share of median income paid is higher for women than men in Ontario, and less so in Quebec and Saskatchewan. Most provinces assess the income of married residents using combined spousal income, split 50/50, following the equity principles underlying matrimonial property laws. Pension splitting for seniors also helps to equalize fees (not taken into account in our estimates because of data limitations). A high or income-based minimum retained income (for the individual and for the community spouse) also promotes gender equity.

It would be helpful for future research to analyze provincial-level data on resident payments (average payments; what percentage pay the maximum, total payments), and to extend the microsimulation begun here to a multivariate analysis of fees across the income distribution. Finally, while this paper focuses on equity, other important questions concern how the resident cost structure influences the supply of beds, wait lists, the allocation of funds at the level of the institution between "care" and "accommodation" services, and the mix of public and private options for long-term care.

Notes

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2. Source: NHEX data tables 2013. Series D3 and D1; 2013 preliminary, <https://secure.cihi.ca/estore/productSeries.htm?pc=PCC52>.
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4. S. Godden and A. Pollock, "The Future of Social Care in the UK," *Research, Policy and Planning* 28/1 (2010), pp. 1–14.

5. OECD, *Help Wanted? Providing and Paying for Long-Term Care* (Paris: OECD Publishing, 2011), p. 215.
6. A. Reimat, “Welfare Regimes and Long-Term Care for Elderly People in Europe,” Paper Presented at the IMPALLA-ESPAnet Joint Conference (6–7 March 2009), pp. 1–25.
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8. H. Gleckman, “Long-term Care Financing Reform: Lessons from the U.S. and Abroad,” *The Commonwealth Fund* 1368 (2010), p. 7.
9. Gleckman, “Long-Term Care Financing Reform,” p. 9.
10. Gleckman, “Long-Term Care Financing Reform,” p. 11.
11. M. Gibson, “Lessons on Long-Term Care from Germany and Japan,” in D. Wolf N. Folbre, *Universal Coverage of Long-Term Care in the United States: Can We Get There From Here?* (New York: Russell Sage Foundation, 2012), pp. 121–153.
12. Gleckman, “Long-Term Care Financing Reform,” p. 15.
13. Gleckman, “Long-Term Care Financing Reform,” p. 17.
14. OECD, *Help Wanted*, p. 215.
15. OECD, *Help Wanted*, p. 239.
16. OECD, *Help Wanted*, p. 236.
17. OECD, *Help Wanted*, p. 234.
18. OECD, *Help Wanted*, p. 272.
19. R. Stadnyk, “Three Policy Issues in Deciding the Cost of Nursing Home Care: Provincial Differences and How They Influence Elderly Couples’ Experiences,” *Health Care Policy* 5/1 (2009), pp. 132–144.
20. See A. Meijer, C. van Campen, and A. Kerkstra, “A Comparative Study of the Financing, Provision and Quality of Care in Nursing Homes. The Approach of Four European Countries: Belgium, Denmark, Germany and the Netherlands,” *Journal of Advanced Nursing* 32/3 (2000), pp. 554–561.
21. See OECD, *Help Wanted*, and A. Blomqvist and C. Busby, “Long-term Care for the Elderly: Challenges and Options,” *C.D. Howe Institute Commentary* 267 (Toronto: 2012).
22. See A. Blomqvist and C. Busby, “Long-term Care for the Elderly,” for a Canadian example.
23. Meijer, van Campen, and Kerkstra, “A Comparative Study of the Financing, Provision and Quality.”
24. I. Chmiel and M. McCracken, *Designing an Improved System of Continuing Care Charges* (Ottawa: Informetrica, 2001).
25. The conversion factors for gross income of $25,000 are .948 (net), .98 (after-tax) and .942 (net after-tax). The conversion factors for gross income of $35,000 are .967 (net), .928 (after-tax), and .901 (net after-tax). The conversion factors for gross income of $50,000 are .978 (net), .860 (after-tax), and .838 (net after-tax).
26. N. Fernandes and B. Spencer, “The Private Cost of Long-Term Care in Canada: Where You Live Matters,” *Canadian Journal of Aging* 29 /3 (2010), pp. 307–316.
27. Note that in AB, the individual pays the standard rate, but at incomes lower than $25,600 an “accommodation benefit” for those in long-term residential care (as part of the ASB) reimburses part of the cost.
28. Stadnyk, “Three Policy Issues.”
29. See also N. Fernandes and B. Spencer, “The Private Cost of Long-Term Care in Canada.”
30. M. MacDonald, “Cost of Facility-Based Long-Term Care: Variations Across Provinces/Territories and Implications,” *Final Report*. Prepared for Health Canada (2014).

Online Provincial Sources for Long-Term Residential Care Fees (websites accessed March 2015)

British Columbia
Continuing Care Fees Regulation
<http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/330_97>
Long Term Residential Care
<http://www2.gov.bc.ca/gov/topic.page?id=4FEC0F570BC04692810548267D09577E>

Alberta
Accommodation Standards, Forms and Publications
<http://www.health.alberta.ca/services/continuing-care-forms.html>
Alberta Seniors Benefit
<http://www.health.alberta.ca/seniors/seniors-benefit-program.html>

Saskatchewan
Special Care Homes Resident Charges
<http://www.health.gov.sk.ca/special-care-charges>
The Special Care Homes Rates Regulations
<http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/R8-2R8.pdf>

Manitoba
Personal Care Services Guide
<http://www.gov.mb.ca/health/pcs/guide.html>

Ontario
Seniors Care—Long Term Care Homes
<http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities.aspx>

Quebec
Financial Contribution by Accommodated Adults
<http://www.ramq.gouv.qc.ca/en/citizens/aid-programs/Pages/accomodation-public-facility.aspx>
Contribution simulator
<https://www.prod.ramq.gouv.qc.ca/Cah/BY/BYG_GereAdheb/BYG6_CalcContb_iut/BYG6_Accueil.aspx?LANGUE=en&cit_en>

New Brunswick
Nursing Home Services
<http://www2.gnb.ca/content/gnb/en/departments/social_development/services/services_renderer.9615.Nursing_Home_Services.html>
Standard Family Contribution Policy, May 2009
<http://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/LTC/StandardFamilyContribution-e.pdf>

Nova Scotia
Department of Health and Wellness, Continuing Care Branch. Resident Charge Policy
<http://0-fs01.cito.gov.ns.ca.legcat.gov.ns.ca/deposit/b10662765.pdf>

Prince Edward Island
Nursing Home Cost of Accommodations
<http://www.gov.pe.ca/photos/original/hlth_ltc_fs1.pdf>
See *PEI Long Term Care Subsidization Act*
http://www.gov.pe.ca/law/statutes/pdf/L-16-1.pdf
Regulations
<http://www.gov.pe.ca/law/regulations/pdf/L&16-1.pdf>

Newfoundland and Labrador
Long-Term Care Facilities and Personal Care Homes Frequently Asked Questions
<http://www.health.gov.nl.ca/health/faq/nhltfaq.html>