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RIDFC Symposium—Health and Long-Term-Care Issues

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Panelists: DR. ROBERT L. BROWN
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Summary: This symposium provides new thought, insight and easy dialogue between many disciplines as professionals discuss the ways the aging population and changing family structures are changing retirement today. Some content is U.S.-centric, but much goes beyond U.S. borders. The research papers are available at http://www.soa.org/sections/pension.html.

MS. RONNIE SUSAN THIERMAN: Dr. Yung-Ping Chen is the Frank J. Manning Eminent Scholar's Chair at the Gerontology Institute at the University of Massachusetts in Boston. He is currently serving a three-year term as an honorary visiting professor at the University of Hong Kong. He participated in the 1971, 1981 and 1995 White House conferences on aging. He was also a member of the 1998 White House conference on Social Security. He served on the panel of actuaries and economists for the 1979 Advisory Council on Social Security as well.

Dr. Chen is an economist with training in law and the mental health sciences, and he is a fellow of the Gerontology Society of America and a founding member of the National Academy of Social Insurance. His research over the years has focused on five main areas: Social Security financing, home equity conversions, private pension coverage, financing long-term care, and older worker employment policy. His research papers have been presented in more than 20 countries, and he currently serves on the board of directors for the National Council of Aging.

I'm going to turn the mike over now to Rob Brown, who needs no introduction. Dr. Brown is going to speak for about 20 minutes, and then Dr. Chen will speak for about 20 minutes. After that, I'll share some of my thoughts or questions and see if they want to respond to them, and then we'll take questions from the floor.

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DR. ROBERT BROWN: In Canada citizens have universal medical care. All ages get their medical care from the government. They still have some private health care, but it's supplemental in nature, and certainly citizens who do not have private health care do not suffer inordinately. Canadians are faced with the problem of the aging population, and there are a number of questions as to how they are going to be able to afford their government-sponsored health care system as the population ages.

I am going to start with just a little bit of background. We know that life expectancy is improving. What's more important is fertility rates have changed. The United States has come back to about a 2.08 fertility rate, whereas Canada's fertility rate has continued to drop to about 1.65. This is not easy to explain.

Culturally, Canada and the United States are two of the most similar nations in the world. Our fertility rates have been very similar over the years, but those have diverged in the last 10–15 years. This means that the United States' replacement ratio, or dependency ratio issues, might be a little bit different compared to Canada's. Canada also had a bigger baby boom than the United States did.

The demographics of Canada show a postwar baby boom that is not worth analyzing or discussing. I would suggest that, in the United States, you did not have a baby boom in 1945. The United States' baby boom peaked in 1957; Canada's baby boom peaked in 1959, did not end until 1966, and has not returned to those levels of live births since then.

So the fact that one group of people will be supported by another group of people presents some interesting demographic issues. Canada's median age is rising very rapidly. The only time the median age ever went down was between 1951 and 1966. This happened during the baby boom, when Canada had so many live births that they actually drove the median age of the Canadian population down. It's now rising more or less with the baby boom. It will peak out at about a population median age of 42 at mid-century.

Canada is at a very good period of time demographically because all of the baby boomers are available to be in the active labor force. Canada's active labor force is supporting a relatively small age cohort—the Depression cohort and the First World War cohort. They are small, relatively speaking. You saw the fertility rates earlier from the Depression years. Canada's active labor force is also supporting a relatively small baby bust and post–baby bust generation. Demographically Canada is at an all-time wonderful point right now.

When the baby boomers retire, they will be in the age-dependency phase supported by a declining number of active workers. However, if I put a relatively serious change in immigration in these graphs, you would not be able to see the difference. Immigration cannot change a 32 million person population pyramid. Canada has

one of the highest immigration rates of any country in the world; it's still just slightly more than 100,000 people a year. By the way, they don't enter at age zero, so they're remarkably different, demographically, than babies.

Quite a remarkable shift is about to take place in the Canadian population. It has been pointed out by so many researchers. The most important aspect might be that the number of elderly, defined as those 65 and older, will double by 2036. However, the number of those ages 85 and older will more than triple. From a health care perspective, this is where Canada gets into some of its expensive years.

Internationally, I'm going to sit comfortably in Canada and wait to see what happens in countries like Japan, Italy and Spain. I don't know personally how they're going to get through the next 40 years. They have shifts that make ours pale in comparison.

From a demographic standpoint, Canada is a bit more interesting than the United States. That is because of our bigger baby boom and more dramatic baby bust. Sweden and the United Kingdom are of no interest whatsoever. Japan and Italy are very interesting, and Spain would be about equally interesting.

What I'm trying to look at is a national-account immunized portfolio. So we must have a liability, and we must have an asset. The asset in this national-account immunized portfolio is our pension system. So here we have some information on contributors and dollars and accumulated assets in the Canada/Quebec Pension Plan. Registered retirement plans are employer-sponsored qualified plans. If you were in the United States, those would be qualified plans. Registered retirement savings plans (RRSPs) in Canada are individual accounts. Those are 401(k)'s, IRAs and Keoghs in the United States.

You have the same opportunity to save for retirement in Canada in a tax-advantaged manner, whether you're in an employer-sponsored plan or not. You can get the same opportunity in a RRSP whether you're in a defined-benefit or defined-contribution plan.

While RRSPs are growing in size, contributions to individual accounts actually exceed employer-sponsored plans. The employer-sponsored plans historically have been far more important, and there are more assets in those. There's not much in the way of assets in the Canada/Quebec Pension Plan because it has been quasi pay-as-you-go until very recently. However, now it's going to accumulate about a 16 percent funding ratio. This will go to about $120 billion in a relatively short period of time.

Let's look at contributors. There's a motivation for this because the government actually seems to look at the pension system in a very negative way. We're going to find out why. The government is also reinforced in its negativity by many of the social commentators. The social commentators say that only the rich benefit from

pension plans and individual retirement accounts. They would normally put up a chart to show that only the rich contribute, and they contribute a whole lot more. The poor people are not advantaged by these systems, but there are, in fact, very significant tax advantages. Your contributions up to the limits are tax deductible, and your investment income accrues tax free. When you pull out your proceeds in retirement, everything is taxable in full. By the way, within limits, both the employer and employee contributions are tax deductible. There are a lot more pension plans with employee contributions in Canada than in the United States.

But the argument is made that this is a system that is good only for the rich. It costs the government money because when you make a contribution that's tax deductible, your investment income accrues tax free. If these things weren't true, the government would reap a lot more tax revenues. They call this negative tax revenue a tax expenditure. They argue that they're losing $14–16 billion a year in tax revenue because of the incentives that they provide for these pension plans and individual accounts.

So that's the asset side of the page. We have this asset called pension plans. Then we have this worrisome growing liability called health care. There are many age-related aspects to the delivery of health care. As the population ages, we see increased health care costs. The health care expenditures are in constant dollars. These are just based on population aging. Health care costs will more than double in a relatively short period of time. The question is, how are we going to pay for this?

You have an asset and a liability. The actuarial question is, how do they stack up one to the other? I pointed out that when you go into a pension plan, you get a tax deduction and your investment income accrues tax-free. When you take the money out in retirement, it's fully taxable. That's future tax revenues for the government. If you push the macropopulation through these tax revenue figures, the money that the government is losing today—these tax expenditures of $14–16 billion—are actually going to turn into unexpected bonuses. When the baby boomers retire, the total population will actually be paying more in tax through the pension system than they'll be taking out, because there will be more people who have retired and are paying income tax than will be putting in and taking tax deductions. So this net government loss of today is going to turn into a net government windfall tomorrow. We're going to go from something like a $15 billion tax expenditure to something close to a $15 billion tax windfall. It's not clear that the government realizes this yet.

On a ledger, there are some pension plan assets and some nice cash flows coming out of it. We have the health care liability, and we're worried about how we're going to pay for the increased costs. What happens if we put these two cash flows together? In Canada this is all within the government. This is money to and from the government. Today the government is losing money because of pension plans. Then they're going to gain money. Today they're paying $41 billion for health care,

and it's going to go up to $81 billion. If you add the impact of all of that together, you get a constant number.

I remember the night that these numbers jumped out of the page at me. This is pretty neat. We've got an immunized portfolio. There's one critical assumption, though. There is really a message I'm trying to get out. This model of the impact of the pension system assumes that we don't have a whole lot of inside limits on the ability to contribute. The inside limits on the ability to contribute in Canada are really holding us back. I cannot contribute more than $13,500 to an IRA in a year at this time. The government looks at it negatively; they look at it as a way for the rich to avoid taxes. What if it's a way for the baby boomers to pay for their health care with exactly the right amount of money at exactly the right time? Would you still discourage pension plans and individual accounts?

How can we relate this to the United States? In Canada we're spending about 9.5 percent of our gross national product on health care, and the government controls about 70 percent of that. The government provides every Canadian with minimalist health care, no user fees, no deductibles, no co-insurance, and they use up about 6.6 percent of our gross national product to provide us with that health care.

We have a pension system that can pay for this for the next 40–50 years if the government would just allow us to take advantage of it. How can I relate that to the United States? I found this little analysis fascinating. In the United States, you're not quite at 15 percent of GNP yet, but it's rising rapidly. The government seems to control about 41 percent of that delivery. You know, there are a lot of people in this debate that think in Canada it's 100 percent, and in the United States it's zero. It's actually 70 percent versus 41 percent. We're not that wildly different.

You have Medicare, Medicaid, veterans' benefits and some other things. The government takes about 6.2 percent of GNP and provides minimalist health care to people age 65 and older and some people in poverty. That's 6.6 percent in Canada and 6.2 percent in the United States. We're talking about the same ballpark. If we could both look at creating the same relatively sized pension plan systems, then it seems to me, demographically, we would have found the source of the funding where the baby boomers will pay for their own health care.

DR. YUNG-PING (BING) CHEN: It's a pleasure to be here to address the question of funding long-term care. For those of you who have been attending this meeting throughout these two days, you must have gotten the signal that funding long-term care is a very important issue for me because of the aging of the population with particular emphasis on the aging of the elderly population. From 2000 to 2040, in the next 40 years, the demographers expect that the 65–84 age group will more than double. There are about 40.3 million in the United States aged 65–84.

What is even more impressive is the projected growth in the 85+ population. That population now numbers about 4.3 million in the United States. In 40 years it's

going to go up more than three times. We all know that as a person ages, the probability of needing assistance will be more likely.

Long-term care is defined as medical nursing and social and personal services rendered to those who need assistance at home, in a community or in an institution. The institution, nowadays, includes an assisted living facility as well as the traditional nursing home. By definition, the rendering of the assistance would have to be for an extended period of time. The functional impairment relates to the fairly familiar activities for daily living.

There are basically two types of long-term-care services. The first is what is known as informal, which is another word for nonpaid long-term care. This type of care is given or rendered by family and friends, and I would say it is mostly families. I would also say that, within families, this is provided mostly by the daughters and daughters-in-law. Then the other type of long-term care is formal, which is another word for paid long-term care rendered by professional providers, such as doctors and nurses and nurses' assistants.

The reason that we are interested more today in formal long-term care is because the supply of informal caregivers seems to be declining. The reasons for that are probably well known to a great number of people at this symposium. We've dealt with the changing family structure, for example. By specifically applying that type of information to long-term care, we can note that the reasons for less availability of informal care, especially as we look farther out into the future, relates to the geographical dispersion of family members.

In addition, there are more women working in the paid labor force; therefore, the amount of time at home is more limited. Then we also have smaller families. Rob mentioned the fertility rate more than once. Of course, we all know that it has been declining. There are fewer children per family. There are also more childless families and higher divorce rates. We've mentioned those and more single parent families, and certainly the number of never married people has increased dramatically in the last 30 years. We are talking about family pattern changes and their impact on the Social Security system.

The last point is very interesting. It relates to the fact that the 85+ population is increasing rapidly. Many of the children are older, and they themselves might need assistance with daily activities. That further restricts or reduces the available number of informal caregivers.

In the United States, for the year 2000, we have statistics to show the distribution of a payment mix for formal long-term care. Medicaid, which is a welfare program, pays about 35 percent. The personal out-of-pocket payment is about another 35 percent. Medicare accounts for 24 percent. Private long-term-care insurance accounts for 4 percent, and other payers make up the remaining 2 percent. These figures are from the Congressional Budget Office, which is a pretty authenticated

source. The total estimate of formal long-term-care expenditures amount is about $100 billion for the year 2000.

What is the best way to fund long-term care? I think most people will say Medicaid is not the most rational way of funding long-term care. For one thing, Medicaid requires impoverishment. People have to be destitute before they can qualify for Medicaid, the state and federal combined welfare program. However, personal out-of-pocket expenditure for long-term care can bankrupt and certainly impoverish a lot of people. Right now the national average estimate for long-term care in a nursing home stay is $55,000 a year. It can go up to more than $100,000 in some boroughs of New York.

Many people receive at-home care because they do not have the severe disabilities or dependency that require them to be in nursing homes. The costs of home care are about half the cost of nursing home care or $27,000 a year. Assisted living runs between $27,000 and $55,000 a year. Compare these costs to the meager income and asset levels that a lot of older people have, especially those in the older age group, the 80+ group.

Let's make the assumption that long-term-care risk is an insurable event. One or two of my colleagues would argue with me on this point. At any given time, a relatively small proportion of the population will need long-term care; however, the particular individuals who will need long-term care is highly unpredictable. On the one hand, you have the phenomenon that very few people, proportionately speaking, require long-term care. The number ranges from about 5 to 7 percent. On the other hand, it is unpredictable, so you don't know when a person will need it.

Given these two features, insurance tends to be the best mechanism for coping with this risk. We could pull together people with the same exposure to the same kind of risk, and the insured can pay a certain amount, in exchange for the potential loss that they could avoid by having such a policy.

If we accept the proposition that insurance is a good way to protect against this kind of loss, then we ask the question, are we doing it well? We know we're not because, in the social insurance area, even if we count Medicare or its spending on so-called long-term care, that's not nearly enough. On the private side, it's only 4 percent. I think it's more than 4 percent, because the statistics we have from the Congressional Budget Office only count what the insurance companies are paying to the providers.

Many of the long-term-care insurance policies pay directly to the insured, and the insured pays the money, in turn, to the providers. It could be more than 4 percent. I personally would hazard a guess that it is 10 percent. That's not nearly enough. Even if we count all Medicare payments for these services as long-term care, it's only 24 percent.

So how do we go from here to accepting insurance as a mechanism, in both the public and private sectors? It's a difficult road, and I have been proposing that we create a social insurance long-term-care program to provide basic long-term-care coverage for people. With that as a base, then I propose that the private long-term-care insurance be strongly promoted to provide a second layer of protection.

On top of that, people can pay out of their incomes and savings to make up the difference. Sometimes I call it the three-legged stool approach, which is akin to the way we provide for retirement income and acute health care for the elderly in the United States.

But, even with the three legs or three sources of funding, we might still have some other people whose needs are not met because they may not be able to save enough to help pay for the third layer or for other reasons. When these three sources are insufficient, then we use a safety net measure that we call Medicaid to help them out.

How do we get from here to there? My model assumes that we have difficulty in coming up with public dollars to create a long-term-care insurance program. We already have trouble coming up with money to shore up the long-term solvency of Social Security and Medicare. I cannot see the government, or Congress or the president of the United States proposing an additional program for long-term care using the social insurance approach, however rational or reasonable or appropriate that might be.

So how do we get a social insurance program to provide basic long-term-care started? This is a rather controversial proposal. I've been talking about this for about 12 or 13 years. Many of my colleagues have been supportive at the intellectual level, but other colleagues have been giving me the silent treatment.

Lately there seems to be a little bit more attention paid to this idea. The idea is not the best; I call it the second best idea. What if we could divert and use 5 percent of retirement benefits, Social Security benefits, to create a long-term-care trust fund? I would exempt low-income recipients of Social Security, but all elders will be covered for the basic long-term-care benefit under this program. I call it the Social Security long-term-care plan. It would entail Social Security being connected with long-term care.

In addition, I would urge serious consideration of adoption of the plan we call a combination policy, especially for private insurers. It provides a long-term-care rider to a life insurance or annuity contract. This is like the critical illness policy that the life insurance proceeds could be used while the policyholder is still alive but needing immediate cash assistance. If the person does not need long-term-care benefits, the entire life insurance or proceeds will be passed on to the heirs.

So one policy is to divert Social Security benefits for the creation of a long-term-care social insurance policy. The other policy is to promote the idea of a combination policy combining the long-term-care benefit with the life insurance or annuity benefits. Then I think we have a chance of making it possible for the insurance concept to be translated into practical programs or measures to help fund long-term care.

MS. THIERMAN: I have a few questions for our guest panelists. I thought I would start off with Rob Brown. His paper, as you know, takes the position that retirement savings produce tax deferral in the working years and then taxable income when the benefit becomes payable in retirement. You talked about the large group of baby boomers that were moving toward retirement. So my question to you is, with the large number of voters and the voting clout that the elder population will represent, might there be huge pressure to reduce the taxation of the benefits that they would be receiving during retirement?

DR. BROWN: I don't know. Canadians, it would appear to me, have bought into a system in which they would be able to defer a significant portion of tax through their registered pension plans. These are either employer-sponsored or individual plans. They understand that, at retirement, this becomes taxable as income. In other words, philosophically, it's deferred income. I don't take it this year, so there's no tax, but I do take it at age 68, and because it's income I pay income tax. This has been available and in existence for a long time. There has never been any suggestion to me that income to a 68-year-old, because it comes out of a pension plan, should be taxed differently than earned income to a 37-year-old.

I would be surprised if that were to happen, but stranger things have happened. Certainly, having lower tax rates now than a few years back lessened the probability of that. We've gone from marginal rates of about 53 percent to marginal rates of about 45 percent. We have free health care, so I don't think it's likely to happen. That is my honest response.

MS. THIERMAN: Now I have a question for Dr. Chen. You were talking about the supply side of the caregiver equation. Today we are experiencing a shortage of nurses and other medical practitioners. I'm wondering if you might comment on this and the significant challenges that it will bring in the future?

DR. CHEN: I'm glad you brought this up. In my work, I concentrate on financing—how to fund the program. I am quite aware of the problem of providers. We have shortages in not only long-term-care facilities and nursing home workers, but also nurses. Believe it or not, there is a shortage of geriatricians.

The issue of supply of providers of all types is a very significant issue. I might be overstating the importance of stable funding, but I do believe that if we could count on stable and sustainable sources of funding, then we could probably help in creating a more stable work force as well. I'll give you just one example.

The Balanced Budget Act of 1997 created havoc on the nursing home and home-health-care agencies because of the cuts in Medicare's spending for those programs. Congress did restore some of those cuts. Some of the medical facilities have already declared bankruptcy, and then with the meager restoration of the customer, it's hard to get that work force back to these institutions again. So my proposal, as well as other proposals, might create stable funding sources.

Other countries rely upon immigrants to render these types of services. In Hong Kong people have a lot of Philippino maids, and in Japan they try to get people from Indonesia. One report indicated that in some communities they even rely on low-level criminals to come out of the jails on a day pass to provide services.

MS. THIERMAN: I have another question for Rob. With the trend toward lump sums and early distribution of retirement benefits without sufficient annuitization, perhaps all of this taxable income that you showed us won't be coming out in quite the time frame you had suggested. Can you comment on that?

DR. BROWN: I don't think it's nearly the problem in Canada as it would be in the United States. First, we have not seen the same overwhelming drift away from defined-benefit plans, even though we have more defined-contribution plans now than ever before. Eighty-eight percent of the labor force is in a defined-benefit pension plan in Canada.

We also have tax reasons for taking your money out gradually and periodically. In Canada you don't have to annuitize to do this. There is a government system called a registered retirement income fund, and the government presets a percentage or a range that you must take out and pay tax on. The loss of this to lump sums or the fact that you would take lump sums and then become dependent on society isn't as strong a danger in Canada as I would predict for the United States.

MS. THIERMAN: Dr. Chen, I think it's a very interesting concept you discussed in your paper in terms of bundling long-term-care benefits with insurance and annuity coverages. I'm wondering if you could comment a little bit on the tax incentives that might be needed to accomplish this.

DR. CHEN: Let me provide a background. At the federal government level, and in many state governments, tax incentives are already available for some purchases of private long-term-care policies. But these incentives don't seem to be very powerful in stimulating sales.

Then why is it? Of course, there are many different reasons why people do not buy private long-term-care insurance policies. This is true despite the fact that, in the new generation of long-term-care policies, the benefit provisions are far more sensible than they were before. There are fewer exclusions and more provisions.

Still, many people don't buy them, and I think there's a very powerful deterrent to private demand for long-term-care policies. That is captured by the phrase "use or lose it." People just don't like the idea of buying a policy and paying premiums for years on end and never using it. They perceive it as a loss with nothing to show for it. This is not correct, of course, because each year, even if you don't use it, you have the insurance value. It is similar to the way you insure your house. If your house doesn't burn down or you don't need an insurance payment, do you feel like you've really been cheated?

Automobile insurance is the same. People dread the thought of use it or lose it. This is what gave me the idea that we really ought to combine the risk. By combining the long-term-care risk benefit with the life insurance or annuity benefit, if you do not need long-term-care services, you won't lose it. At the end of the day, you get the income protection for your heirs. However, if you use it, all you do is reduce the amount of inheritance for the beneficiaries of the policy. This should, I think, encourage people to take it out. This has a benefit from the insurer's point of view because the moral hazard is one major concern of insurer's. This combination policy might not eliminate it, but I think it will greatly reduce the moral hazard because moral hazard means overuse of services.

If they overuse services, they will reduce the amount available for income protection, so there is a tendency not to overuse. The insurance companies are concerned about adverse selection. If you combine the two, you cover both the healthy and not so healthy so that there are offsetting tendencies. I think it will neutralize the hazard from adverse selection.

DR. BROWN: Can I just reinforce that last point, because it almost slipped by? If there are two separate companies—one offering long-term-care insurance and the other offering life annuities—the two prices for those individual products would be greater in total than if you put them together. For example, say if someone is admitted to a long-term-care facility because they have lost so many activities of daily living indicators or they've become disabled. That's an automatic indicator that their life expectancy is lower than average.

You've got a reserve release in your annuity account. You should be able to price that bundled product more cheaply than if you were to price it as two separate products.

MR. MIKE SWIECICKI: I am with CalPERS and we have about 140,000–150,000 long-term-care policies in force. But I have a question on something that Mr. Chen brought up. Has there been any discussion on a national level about immigration policy that might be able to assist other countries in training people who could work in the long-term-care field? The Philippines and Mexico come to my mind fairly quickly. Perhaps nurses or nurses' aides could work and relieve the pressure that the labor markets have in this area. It could benefit everybody—other countries, the long-term-care industry and this country.

DR. CHEN: Yes, enormous studies are ongoing on this particular issue in Philadelphia and elsewhere. We're talking about long-term care. Each decade has had a wave of immigrants. It seems that the immigrants have been the source for these types of jobs.

I think we should be able to start something on a more organized level to train these people. Once again, I would caution that if you do not have stable funding sources for nursing homes, home care agencies or assisted living facilities, then it's very difficult to urge individual companies to embark upon a training program because, once trained, these individuals could perhaps leave and work for a competitor.

However, I can see the need for it, and we should work for more training. We need some collective approach to this rather than relying on individual organizations to do the training, because of the issue of retaining those workers once they train them.

MR. DOUGLAS ANDREWS: Rob, I have three comments for you. First, you showed that net cost is constant between the tax expenditures and the health care costs. However, what that means is that you have to maintain a constant flow of tax dollars. With the changing demographics of the baby boomers getting older, they probably will not be there to pay the taxes, so how is that going to work? Doesn't that mean greater taxes for workers?

Second, in terms of the methodology. Your methodology, in any event, gives you net tax expenditures, which, in one part, are dollars that aren't being taxed. Another part is dollars that are being taxed. You're netting that against actual dollars that have to be spent on health care.

I think it would be easier to see if the number was constant, not if you were just using withdrawals that are actually being taxed creating dollars and the health care moneys that are requiring tax. Those health care dollars do continue to go up; they don't stay constant.

Finally, you've said that the pension and the health care is all part of government. In Canada, as you're well aware, it's the responsibility of different governments. As such, the pension is based on the federal government receiving the tax, whereas the provincial governments have responsibility for the health care. They don't always work in a coordinated effort. So there's real potential that the tax may come from one part and not get to the other part. The one government might reduce the taxes, and the other government will need the money.

DR. BROWN: Those are good points. We're now getting into Canadian politics. Will income taxes in total go down after the baby boomers retire? I've rephrased your question slightly. Adam Smith is going to force an equilibrium of production and

consumption. People are going to be working a little bit longer, so I don't think income taxes on earned income are going to go down as much as you might think they would if all the baby boomers retire at age 62. There has to be an economic equilibrium of production and consumption that leads you to believe that there will be close to an economic equilibrium in income taxes that are being collected before and after.

Net tax expenditure is a lousy statistic. In fact, my definition is a little bit different than the federal government's definition. I don't allow any credit or any tax expenditure on interest income accruing after you retire. My model doesn't allow for that, which actually makes my case a little rosier than the minister of finance would calculate. By the way, the ministry has changed their attitude toward tax expenditures. My understanding is that $16 billion that I showed is now more like $8.5 billion or $9 billion because of some philosophical differences that they now accept.

The federal government is going to get these tax revenues, and the provinces are going to incur the health expenditures. That will be a political bargaining position, and it will be difficult. We've already seen this. The federal government transfers certain tax points to the provinces, and they've bundled them. They're supposed to pay for education and health. What has happened over the last 10 years is they've taken the total transfer and paid for health, but they haven't provided enough for education.

Those kinds of games can go on, and we'll have to stay on top of the politicians to make sure that we somehow get those cash flows to the areas that need them.

FROM THE FLOOR: I want to pick up on the question about lump sums. I work on our own in-house plan where I would say 75 percent of the money does go out in lump sums. However, I also get to see where it goes, and I would say probably another 75 percent of that money is voluntarily rolled over into IRAs. I think if you get caught up in the employer-provided pension sector, you might be missing a vital piece of the fact. What looks like a lot of money going out in lump sums ultimately gets annuitized in some form, whether it be interest on principal or however the person ultimately handles his or her IRA.

I want to pick up on your question about budgeting and how we look at long-term impacts of policy actions. You're analysis does depend on looking not only at the short term, where there is a loss of revenue, but also at the long term, where there's a gain of revenue from that same source.

I wonder if we don't need to press for government budgeting that looks more at the long-term impacts. For example, we just went through the Economic Growth and Tax Relief Reconciliation Act in the United States, where we phase in a whole bunch of things up until 2010, and then we wipe them all out because we can't look at the budgetary impacts beyond 2010.

The Roth IRA is the reverse of what you're suggesting. In order not to lose revenue now, we lose revenue later when we might need it the most. I'm not sure how it works in Canada, but I'm wondering if we don't somehow need to find in the political process a way of forcing a longer-term view of the total revenue impact. Maybe not a 75-year view like Social Security takes, but at least a longer-term view than we now have.

DR. BROWN: One of the biggest problems with talking to Canadian politicians is that their time horizon is four years. Their big concern is getting reelected. If I tell them something is hurting them today, but it's really going to be good in 2035, they don't get all that excited. If I could somehow show them it's going to help them get reelected, then I'd get their ear. This is always difficult. I can remember in the early 1980s going to sessions saying, "You ought to amend the Canada Pension Plan now so that we can have a very small increase in contributions and not have to take the huge leap later." They waited, and they waited, and they waited until they had to go from 3.6 to 9.9 percent. If they'd done it earlier, it could have been 7.3 percent. They're concerned with whether it is happening during their term. If it's not, they want you to go away because it's not their problem.

I just want to put a little bit of color to some of the statistics you've seen on long-term care. It's easy to build an image of an entire society of 85-year-olds in nursing homes. In fact, that's not going to be the case. The wonderful news is that the period of time that we spend at some level of disability is not lengthening as life expectancy lengthens. There are lots of different studies, and they don't all agree 100 percent, but the general indication seems to be that we really are getting healthier.

FROM THE FLOOR: I just did an armchair calculation of long-term care while listening here. The purpose is to try to show it's not a heavy cost that a social system could assume. My statistics might be in error slightly because I haven't attended all these long-term-care sessions.

Let's suppose that it costs $50,000 a year for nursing home care. On the average, you stay in there for 14 months before you die. Let's suppose you go into the home 12 years after age 65 or at age 77. If I assume 6 percent interest, I come up with a calculated value of only about $9,000 that's needed at the time that you're 65 to provide for that benefit.

Assuming these estimates are on the money, isn't that a nominal amount that a social system could assume rather than have a marketing effort where people prefer not to buy anything for themselves? Maybe I'm off on my figures; what do you think?

DR. BROWN: I would add one thing that would drop your costs a little bit more. I would suggest that you could legislate that those same people must first provide

their OASDI dollar benefits to pay for their long-term care. I was asked, "How do you pay for long-term care in Canada?" Basically, our Social Security income is enough to get pretty minimal long-term care, and a guaranteed government benefit can buy a place in long-term care.

Remember that the long-term-care institution doesn't have to pay out of their pockets for medical care. The first thing I would do is legislate that your OASDI dollar benefits must also go into paying for your long-term care, and then your cost factor would come down even further.

DR. CHEN: I think you're wrong; the picture on long-term care in Canada is not like that. The $55,000 a year is the national average—that's correct. But you cannot assume that 14 months is the length of stay in a long-term-care facility before someone dies. The average length of stay is actually 2.5 years. The offsetting piece, though, is that about 74 percent of nursing home residents do not stay more than a year. So 26 percent stay more than a year, and some of them will be there for 5, 10, 15, 20 or more years.

I wish you were right about the 5 percent that you assumed. It's much more manageable. You're saying you'll pay for the $9,000 annual premium.

One thing is very important. I would like to correct Rob, because he dramatized something. I don't want to leave the impression that I was talking about a nation of 85-year-olds in nursing homes. I also indicated that, at any given time, only a small percentage of the population, even the 65+ population, is in nursing homes—about 5–7 percent. There should not be this image that by 2040 there will be 14 million over-85–year-olds in nursing homes. That's not a correct image.