

“When I’m 64...” – Defining Care Giving Policy for an Aging Canada

Evelyn Shapiro

Senior Scholar

Manitoba Centre for Health Policy

Dept. of Community Health Sciences

Faculty of Medicine

University of Manitoba

Presented at the Conference of the Institute for Research in Public Policy in

Montreal, Que., April, 2009

“When I’m 64...” – Defining Care Giving Policy for an Aging Canada

Introduction

Preparing this presentation on the challenges we face in caring for older Canadians proved to be, for me, already a pretty old Canadian, both a blessing and a curse. Having been a child during the Great Depression, a young adult during WWII, and a participant in health care policy-making during the post-war era and beyond, the blessing was that it gave me the opportunity to look back and review the progress we made in caring for older Canadians over the last thirty-odd years. The curse is that this reflection on the past has left me gravely concerned about the regressive policies now being enacted or proposed – policies that are likely to endanger the progress we worked so hard to achieve.

In the early 1970s, just after the federal government had ensured universal coverage of both hospital and medical care, the publication of a spate of federal and provincial reports stressed the need to turn our attention to improving and expanding home and long-term institutional care. The result was a federal-provincial agreement to cost-share these programs by using the provisions of the CHA to share the medical care costs and using

the provisions of financial needs-tested CAP to share the costs of providing social supports, part of which the federal government was already sharing for people receiving long-term institutional care. Having just recently started to work on home care policy and program development, it was exciting to attend the first meeting of the federal-provincial National Working Group on Home Care held in Ottawa in 1974 when the federal and provincial delegates worked together to develop a common definition of home care. We agreed that home care should be described as a unique health and social program designed to serve persons with temporary or longer-term disabilities and inadequate social supports to return to or remain at home. It was also gratifying to see these programs subsequently expand across Canada and then also assume the responsibility for assessing persons seeking admission to long-term care institutions.

As I look back now, this federal-provincial co-operation helped to usher in a period of major advances in caring for older Canadians. Since further progress then seemed inevitable, we even began discussing the possibility of developing national standards of care. Those were heady days indeed!

However, federal-provincial relations soured not very long after that when the federal government changed the existing cost-sharing

arrangements with the provinces unilaterally. It replaced the health-related costs with a block-funding arrangement and totally rescinded the CAP that co-shared the cost of social services. The provinces assumed the full financial responsibility for both programs but the changes made by the federal government without prior consultation with the provinces resulted not only in recriminations but also distanced the federal government from a direct stake and, therefore, from any direct voice in the further development of home and institutional care. Thus, even though the more recent Romonow Commission Report resulted in the federal government's recommitment to the provisions of the CHA and provided additional funds for some specific types of home care services, there was no formal commitment to ensure the accountability or the continuity of this arrangement.

Today, in addition to the almost-constant budget-related bickering between the federal government and the provinces, several major developments are undermining the possibility of agreeing on national standards of care and are threatening to undermine some of the tenets that are essential to maintaining, let alone improving, the lot of older Canadians. To understand what these developments are and their implications for home and long-term institutional care, a few of them can be briefly summarized as follows:

First, although you specifically excluded hospital and medical care from your agenda, what is happening now in regards to these services cannot be ignored because they have such an intimate relationship with both home care and long-term institutional care. After all, older Canadians use physicians and hospitals more than other adults and those who are receiving home or institutional care because they suffer from chronic diseases and disabilities use them even more than other older Canadians. Furthermore, and even more importantly, they move more frequently between these resources. How smoothly and easily these transfers are made is, therefore, critical to their welfare.

Sadly, however, our government does not appear to be committed to maintaining the basic provisions of the CHA. For example, this government has failed to respond to the privatization of hospital services even though academic research done in several provinces demonstrates that: 1) patients of surgeons who work in both private and public hospitals have longer waits for an operation in a public-sector hospital than patients of surgeons who work exclusively in the public sector; and 2) this is happening at a time when, as a very recent bulletin from the Toronto Institute for Clinical Evaluation Services points out again, how critical hospital and medical care are for elders and how much their use increases as they age. Since hospital

and medical care, as I noted earlier, also have a key connection with home and long-term institutional care, this lack of commitment to Medicare seriously disadvantages older Canadians, especially as they grow even older.

Second, over the past few years some of the provinces have changed their policies in regards to home care and long-term institutional care. Policies that were designed to serve elders who needed institutional care and who contributed to its cost in line with their income have been transformed into policies that treat elders as customers who have to buy more and more of what they need. What's more, the quality of services delivered is not necessarily guaranteed. The ways in which these changes are being made vary varies by province but these changes include:

- setting time limits on the home care services they provide, forcing their clients to buy some of the services that they have been assessed as needing on their own without guaranteeing the quality of the purchased services;
- reducing the number of nursing home beds;
- “unbundling” the services previously provided as a given in nursing home beds and charging extra for some of them;
- encouraging private entrepreneurs to build “supportive” or “assistive-living” housing for which the tenants pay the owners of these facilities not only for their room and board but also for some of the services which would

have been provided in care facilities and for which they would also have received quality of care oversight. One sad and ironic aspect of this latter step is that it is being “sold” to elders as a benefit because it allows them to “age in place” when, in fact, the greatest beneficiaries are the owners of these facilities. One headline in the Edmonton Journal has called this policy “Aged Care a Growth Industry for Investors” to which it added the subheading “Government Funding Subsidizes Profits from Pensions of Seniors. ”

With the foregoing changes and others that are likely to follow as a result of the current economic downturn , we are beginning to witness the looming pauperization of the already-physically disadvantaged poor and middle-class older Canadians, the majority of whom are very elderly women. Furthermore, we are also beginning to see the development of residential “ghettos” where residents are housed in line with their financial status rather than being served in line with their care needs. (Incidentally, if you think that the coming tide of baby-boomers will be richer than their predecessors and, therefore, able to pay more for their care, you may want to think again – the current rise in unemployment, the loss of pensions and the lower return from their own investments may leave them no better off or less well off or some even worse off than their predecessors.)

However, along with the foregoing factors and the state of federal-provincial relations, the most important reason for my pessimism about the future of home and long-term institutional care is that the policies being enacted or envisioned are changing our commitment to treat health and social services as a communal responsibility to ones that treat these services as commodities for sale if you can afford them without any assurance as to their quality. One example of this danger is the current enthusiasm with which conservative groups are selling remedies such as Medical Savings Accounts that has been shown by academic researchers to penalize the poor who are not only poorer but also sicker than their peers. Other similarly-inclined groups are also touting the benefits of getting people to buy personal insurance even though they must be aware that the U.S., which uses it for its health care system, not only has 45 million people uninsured but costs the government more of its GDP than any other country in the Western industrialized world. I have, therefore, come to the conclusion that the only way forward is to for the federal and provincial governments to pool their resources in order to stop the bleeding of our social safety net. In addition, I propose to offer the following suggestions to each of three levels of government that might help improve but at least maintain the lot of older Canadians who need home or long-term institutional care.

Federal Responsibilities

The first and foremost responsibility of federal government is to ensure that the provinces adhere strictly to the basic provisions of the CHA and that any contravention of these provisions will result in punitive action. This would make it clear that hospital and medical services to which we all contribute are not for sale and enable all transfers between them and home care or long-term institutional care to be accomplished as fairly, as smoothly and as quickly as possible.

Another responsibility is one that derives from a commitment which the federal government made by providing the extra level of home care funding to the provinces that followed the publication of the Romanow Report. I strongly support the continuation of this commitment but with the proviso that the provinces produce evidence to confirm that the monies were spent for that service. It may be useful to note here that, if the government aims to use its so-called “bail-out” package to increase the number of available jobs across Canada, it could do no better than devote part of this money to hiring more home and institutional care workers, the majority of whom are para-professionals and home helpers who are among the lowest-paid workers in the country.

Finally, older Canadians might benefit if the government would encourage its federally-funded research agencies to increase the number of studies seeking to improve our capacity to deliver more effective, more efficient, and especially better quality services in home and long-term institutional care.

Provincial Responsibilities

Most of the provinces have retained their overall policy and funding functions but have also set up regional authorities to whom they have delegated a number of governance and health services delivery functions that include home and long-term institutional care. While this arrangement is touted as the best way to respond to the local needs of each region's population, it adds another level of governance that relies heavily on how well the province oversees the fairness with which each region applies the same criteria for access, service delivery and quality of care as another. In other words, the province should know whether differences in service delivery between one of its regions and another can be explained by differences in the characteristics of those who live in them. Also, individuals moving from one region of a province to another should be able to take it for granted that they will be able to receive similar services and of similar quality of care as they did before. These and a number of other issues

place an onus on the provinces to ensure that its regional authorities fulfill the intent of their policies. In view of the precarious health of the population in these programs, provincial oversight is critical to ensure that the population in its regions has equitable access to the programs' services, an equitable distribution of resources consistent with the characteristics of its population and has built-in mechanisms to assess, maintain and improve the quality of care delivered to its citizens. In order to do that, the province must have a basic information system that provides it with the data it needs to fulfill this obligation. This oversight also provides the province with the opportunity to identify current or potential issues or to recommend programs that have been tested and proved effective in improving the efficiency and/or the quality of care in one region to its other regions.

To provide this oversight, the province also needs to have an internal, qualified staff to analyze the data it receives from its regions, to brief the government on its findings and to report back these findings to their regions for their own and comparative purposes.

The province should also be encouraging its provincially-funded research agencies to engage its scientific community in promoting studies on home and long-term institutional care that stem from the issues raised by the findings arising from the data submitted by the regions. Furthermore, maybe

some day, the provinces might consider the advantages of working together to share ideas and even to develop a national minimum set of care standards. In view of my previous comments, my persistence on national standards may just be a pipe-dream but I have, I think, some good reasons for clinging to it because: 1) any national progress in caring for vulnerable elders is desirable; 2) such a step forward is possible because the provinces meet from time to time to discuss items of mutual interest so discussions on this topic can be accommodated within this framework; 3) some, if not all the provinces, already have criteria which can form the basis for initial discussions and the staffs who work in this field are knowledgeable about how to improve the care they provide to their clients; and 4) the most urgent topic among those to be addressed is improving quality of care.

Responsibilities of the Regional Authorities

The core of the management of home and long-term institutional care in most provinces rests with its regional authorities. They are generally charged with regularly and systematically reviewing their population's needs, establishing the current criteria for access and priority of entry to ensure equity, maintaining an information system to help them review their performance and working to improve staff training, service delivery and quality of care.

Each regional authority should also be encouraging and/or partnering with their local academic institutions to engage in research that tests alternate models to help improve their ability to assess need, deliver services, provide quality of care assurance or other aspects of home or long-term institutional care.

Conclusion

It is clear from what I have said thus far that I am less optimistic about the future of those who have yet to reach 64 and who may subsequently need home or long-term institutional care than I was when we agreed that health care was a community responsibility and not a for-profit generator for private entrepreneurs. Sure, older Canadians are healthier and living longer before they need help but unless we reject our recent path, they may well be left to shift for themselves in whatever premises they can afford to rent and get whatever services of whatever quality they can buy. If we want to succeed in improving home and long-term care for older Canadians, we need to support the principles underpinning the CHA and apply them to another act that responds specifically to the health and social support needs of those requiring home and long-term institutional care. To illustrate the policies I regard as sound, I cite the following excerpts from the 2008 WHO document issued by its Commission on the Social Determinants of Health:

“ The Commission considers health care a common good, not a market commodity. Virtually all high-income countries organize their health-care systems around the principle of universal coverage (combining health financing and provision). Universal coverage requires that everyone within a country can access the same range of (good quality) services according to their needs and preferences, regardless of income level, social status, or residency and that people are empowered to use these services..... The Commission advocates financing the health care system through general taxation and/or mandatory universal insurance....The evidence is compellingly in favour of a publicly funded health-care system.”

My fervent hope is, therefore, that I will yet live to see us reject any policy that treats any health care component, including home and long-term institutional care, as a commodity instead of a common good.