



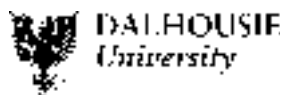
*Promoting social change through
policy-based research in women's health*

The Status of Canadian Nursing Home Care: Universality, Accessibility, and Comprehensiveness

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Introduction

As Canadians, we value medicare and the five principles on which it is based: universality, comprehensiveness, accessibility, portability, and public administration. In particular, we are proud of a system in which every Canadian (universality) has access to all medically necessary services (comprehensiveness), regardless of ability to pay (accessibility).

We live in an era in which the definition of health is being broadened to include health promotion and disease prevention as well as treatment, and in which health is recognized as including not only the health care sector but housing, income, social services, education, and environmental protection. Furthermore, we are increasingly recognizing that chronic health care conditions and disabilities, including those associated with aging, call for a different kind of health care: one that is more socially and care- versus cure- oriented, and one that respects the dignity of individuals who have contributed and still contribute to our society while they cope with significant health problems.

These forces expand our expectations of what should constitute health services. Few Canadians realize how narrowly our health care principles are applied in our health care system through the Canada Health Act. The Act covers only medically necessary services, provided by a physician or hospital. Other services certainly exist, but are not insured under the Canada Health Act, nor do the five principles on which the Act is based apply to these services. Economic, demographic and political pressures serve to further narrow the scope of publicly-funded health care services at the very time in which we are awakening to the understanding of the need for health care to be more broadly focused and client-centred.

The case of nursing home care¹ across Canada is one that illustrates the chasm between the ideals and the reality of universality, accessibility and comprehensiveness of health services that fall outside of the Canada Health Act. There are substantial differences across Canada in terms of the kinds of care available, the costs borne by individuals for such care, residency requirements, and waiting times. As Greb et al. (1994) state, nursing home care across this country has developed as if the provinces were 10 separate countries. The Territories also have their own unique nursing home care systems. This would not be

¹For the purposes of this paper, nursing home care refers to Type II care as defined by the Federal-Provincial Working Party on Patient Care Classification (1973): availability of supervision, assistance with activities of daily living, and personal care on a continuing 24-hour basis, with medical and professional nursing supervision and provision for meeting psychosocial needs. Although each province has its own way of categorizing facility-based long term care, most provinces have a level of primarily residential care which has less assistance available than Type II care, and a chronic care level of care which has much more intensive medical and nursing care than Type II care.

a problem if the differences could be interpreted primarily as responding to local or regional needs and preferences. Instead, the differences constitute serious inequities across the country that challenge the spirit of the principles upon which the Canadian health care system is based.

This paper has 3 purposes:

1. to describe the policy context that supports Canadian beliefs in accessibility, comprehensiveness, and universality of health care, including nursing home care;
2. to compare nursing home care policy in the provinces and territories in terms universality, accessibility, and comprehensiveness; and
3. to explore social forces that impact on current inequities, and possible solutions to current inequities.

Part 1. The Expectations of Canadians: Canadian Policy and Rights

“Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it.”

Justice Emmett Hall

Quoted in Health Canada, 2002, *Canada Health Act Overview*

In this section I will provide a brief review of the parts of the Canada Health Act and the Canadian Constitution. These documents are the basis for the perception that our entire health care system is, or should be, universal, comprehensive, and accessible.

Our health care system is much admired throughout the world. Contrary to popular belief, it is not so much a public health care system as a public system of insurance. While administration and delivery of health care services is the responsibility of provinces and territories, health insurance is a federal concern. The original two acts, the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Act (1966) had the objectives of ensuring that every Canadian had access to all medically necessary services regardless of ability to pay, and to ensure that Canadians would not suffer financial hardship from having to pay medical bills (Kirby, 2002).

The Canada Health Act (1984) reaffirmed these objectives in the statement of five principles. In a recent comprehensive review of the federal role in health care (Kirby, 2001a; Kirby, 2001b; Kirby, 2002) (hereinafter referred to as the Kirby Review), Senator Kirby notes that four of the principles are patient-centred. The fifth, public administration, prescribes the way in which the other four principles should be achieved.

The four patient-centred principles, which Kirby notes “have now achieved iconic status” (Kirby, 2001a, p. 5), outline the characteristics of what services will be insured and who is entitled to insured services.

Universality– all insured residents must be entitled to insured health services under uniform terms and conditions.

Accessibility– reasonable access to insured health services unimpeded by charges or discrimination based on age, health status, or financial circumstances. Reasonable access means “where and as available.”

Comprehensiveness– the health insurance plans of provinces and territories must insure all medically necessary services.

Portability– persons can be insured for health care if they are absent from their home province or territories. This principle, however, does not entitle a person to seek services in another province (Health Canada, 2002).

These principles tell the provinces how they must operate if they are to receive federal funding for health care. Thus the principles have exerted a powerful organizing influence in provincial health matters.

There are limitations to the Health Act, however. One is that it only covers “medically necessary” hospital and physician services. Usually, medically necessary services are related to an identified medical problem (illness or injury) of the individual. A hospital stay, including accommodation, nursing services, diagnostic services, surgery, and medications administered in the hospital would be insured. Physician services outside of hospitals, such as examinations, diagnostic tests, and treatments, are generally covered. Physicians and provinces/ territories often negotiate which services will be deemed medically necessary. For example, some services rendered by physicians, such as some types of cosmetic treatments or surgeries, are not covered because they are not deemed to be medically necessary. Also, medical examinations required by a third party such as a school, employer, or private insurer may not be covered because they are not medically necessary.

The most serious limitation in the Act is that it covers only physician and hospital services. Thus, other important locations and kinds of service, such as home care, nursing home care, and pharmacare, are not covered. While these services may not be insured under the Canada Health Act, they are often available and funded under provincial health insurance plans. Provinces are free to develop their own systems and insurance for these services. Thus each province has created its own systems for care, embodying to a greater or lesser extent the five principles of medicare.

Means testing is one factor that results in differences in long term care service access from province to province. Services which fall under the Canada Health Act are not means tested. In contrast, many of the services not under the Canada Health Act are means tested— that is, individuals requiring the service will be assessed a fee based on their income, or perhaps income and assets. Home support and nursing home care are often means-tested. The way means testing works differs from province to province. In addition, there are numerous other provincial differences in the way provincial long term care has evolved, including different service amounts, types, and eligibility criteria. Differences in eligibility criteria and means testing may result in Canadians being denied services, or denied funding for services, in one part of the country that they would be able to obtain in another.²

² Differences in eligibility may limit access to Canada Health Act insured services as well. It is important to note that means testing and admission criteria are mechanisms for rationalizing scarce health care resources. Each province must decide how best to serve its population with the limited resources at hand. Eligibility criteria, service limits, means testing, and wait lists are the reactive mechanisms used to balance the supply of available services with the needs (and preferences) of citizens. The difficulty is that when different criteria are applied in each jurisdiction, inequality of access can result.

An example illustrates these points. A woman with Alzheimer's disease lives at home with her husband. When she is at home, her medications, the visiting nurse, and the home support worker who helps with meal preparation and her personal care are not insured services under the Canada Health Act. The visiting nurse's costs are covered by provincial insurance. There is a provincial pharmacare plan, which requires a co-payment for some medication and does not cover some of her medication at all. She and her husband also co-pay the cost of the home support worker. The amount of their payments are based on their income.

The woman gets sick and is diagnosed with pneumonia. Her doctor's visit is a Canada Health Act insured service. Her doctor decides to admit her to an acute care hospital. Her hospital stay, medications, nursing care, and physician care, are all insured under the Canada Health Act. If her community offered intravenous medications through the home care program, her doctor might decide not to admit her to hospital and instead request extra health care services in the home. She might receive equivalent medications, supportive nursing, and physician visits at home as she would in the hospital, but only the physician visits would be insured under the Canada Health Act. The other services would be subject to the eligibility criteria and means testing of the home care program and pharmacare program in her province.

When the woman recovers from pneumonia, she is too frail to stay safely in her home. She is admitted to a nursing home, where she receives meals, shelter, assistance from staff, nursing care, and physician visits. The physician visits are the only service insured under the Canada Health Act. The rest of the costs are paid by the provincial government or by the woman and her husband.

The example becomes even more complex if two provinces are compared. For example, in Ontario, home support is not means tested, while it is in Nova Scotia. Copayments for pharmacare plans also vary widely across the country, as do the medications that are eligible for coverage under each plan.

It is surprising that nursing home care was not included under the Canada Health Act, because it existed at the time of the original two acts upon which Medicare is based. The Kirby Review serves to at least partially explain why nursing home care was not included and has thus been subject to provincial differences in its development, particularly of funding mechanisms.

During the late 1950s and 1960s, the only major channel for the delivery of health care services, other than doctors and hospitals, was nursing homes. Since the federal government was already contributing to senior citizen incomes through the Canada Pension Plan (CPP) the Old Age Security program (OAS) and the Guaranteed Income Supplement (GIS), it was felt that access to these services was being adequately ensured through those programs. (Kirby, 2002, p. 15)

Unfortunately this perception, and the resulting lack of attention paid to issues surrounding nursing home care and provincial differences, persists. Both the Kirby Review and the concurrent Federal Commission on the Future of Health Care in Canada (hereinafter referred to as the Romanow Commission) (Romanow, 2002), have noted the need to insure more community-focused services such as home care and pharmacare, and the need for some kind of a national program, or strategy in these areas. The whole area of funding of nursing home care, and in particular the regional inequities in access to nursing home care, receives much less attention but is at least mentioned in both reports.

To summarize, Canadians have embraced the medicare principles of universality, comprehensiveness, accessibility, portability and public administration as the hallmarks of Canadian health care. However the actual requirements for provinces to apply these principles is limited to insured services, which are medically necessary physician, diagnostic and hospital services. Recent reviews of our medicare system recognize that this narrow application is out of step with current and desired directions of health care. While these reviews specifically mention that Canadians have different access to nursing home care because its development in each province and territory does not adhere to the 5 principles (Kirby, 2001a, p. 10; Romanow, 2002, p. 16), it is not clear whether rectifying this situation is a critical item on the health care reform agenda.

The Right to Health Care: The Canadian Charter of Rights and Freedoms

An interesting part of the Kirby Review (Kirby, 2001a) is a consideration of whether Canadians have the right to health care. The conclusion of the experts consulted by the Review was that Canadians have a right to life, and by extension to health and to health care. They based this conclusion on the following two sections of the Charter:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. (Department of Justice Canada, 1982)

For the purposes of this paper, the question of the right to health care is worth considering. In the case of nursing home care, Canadians apparently have different access depending upon where they live, particularly regarding the personal financial contributions they must make to the costs of nursing home care. Factors such as marital status and gender relate directly to income available to meet the financial responsibilities of care. Most importantly, health status itself financially disadvantages elderly persons who live in some parts of our country and require nursing home care. These issues will be discussed in more detail in the following section.

Part 2. A Comparison of Nursing Home Care Access in Canada

In this section, I will highlight some differences in access to nursing home care in Canada. I will then discuss the universality, accessibility and comprehensiveness of nursing home care in Canada in more detail, in light of these differences.

Personal Costs of Nursing Home Care

All Canadians contribute to the cost of their nursing home care. The mechanism of contribution differs from province to province, and may be based on a flat rate or means test. All provinces have mechanisms to ensure that anyone who requires nursing home care can receive it, regardless of ability to pay. It is also worth noting that access to nursing home care in each province of Canada is now through a “single entry system,” meaning that all applicants are assessed and nursing home care is allocated based on the need for that level of service.

Two recent Canadian studies provide detailed comparisons of policies regarding personal contributions to nursing home care costs in 9 provinces and 2 territories (Alberta Health and Wellness, 1999; Federal-Provincial-Territorial Advisory Committee on Health Services Working Group on Continuing Care [WGCC], 2000). Based on a review of these documents and interviews with key informants from government agencies and caregiver support groups in several provinces, I conducted a pilot study to examine the policies in terms of their impact on persons seeking nursing home care, and on community-dwelling spouses (Stadnyk, 2001).

Table 1 describes the differences in the personal contributions that persons residing in different provinces must make to nursing home care. There are three models of policies concerning personal financial contributions.

Per diem-based model (Alberta, Territories). A per diem rate is set based on typical (public pension) incomes available to individuals, leaving a comfort allowance for personal items. The per diem is meant to cover or contribute to room and board costs.

Income-based model (BC, Saskatchewan, Manitoba, Ontario, Quebec). In these provinces, a per diem rate is determined for individuals, adjusted to actual income. As in the previous model, the per diem is collected to contribute to the costs of room and board only (up to approximately \$80.00 per day), but there is recognition that persons with more income can afford to contribute more to these costs.

Income/asset-based model (Nova Scotia, Prince Edward Island, New Brunswick, Newfoundland). In these provinces, a per diem rate is set by nursing homes and government agencies, which includes not only room and board costs but care costs as well. The individual is responsible for paying the full per diem (up to approximately \$160 per day), and may apply for a subsidy if he/she is unable to do this. The person's income and assets are formally assessed in determining eligibility for a subsidy. When assets are examined, there are basic exceptions: for example, usually \$5000 is exempted from the review of assets, and the family home is exempted. Funeral costs may be prepaid. Within this policy model, there are also variations in the kinds of assets considered, the number of years reviewed for evidence that the person has divested their assets in order to qualify for a public subsidy, and so on. The amount of income and assets to be applied to the cost of care is calculated and must be "spent down" before the person's care is subsidized by public funds, although the exact mechanisms of this differ from province to province. The principle behind this kind of policy is that citizens should be responsible for the full cost of their own care, but will be subsidized if they are unable to fully fund it.

Table 2 further illustrates the three models of policies by presenting one provincial example of each.

Issues Arising from Different Funding Policy Models

A key finding of the pilot study was that the issues raised by key informants differed by policy model. In the per diem-based model, issues focused on wait lists and quality of care. In the income-based model, issues focused on wait lists, quality of care, and fear of repercussions if complaints about care were made. In the income/asset-based model, issues focused primarily on financial concerns and quality of life issues for the community-dwelling spouse, such as being able to manage on income/ assets available; tension between "personal responsibility," maintaining a "reasonable lifestyle," and maintaining "former lifestyle"; and concerns about children's inheritance. Key informants also talked about persons avoiding nursing home care specifically because of what it would do to the individual's or family's financial situation. To a lesser extent, care-related issues were also raised, such as the stigma surrounding nursing home placement, and fear of repercussions for making complaints. It is clear that the income/asset-based policy model creates significantly greater financial responsibilities than the other two models, and that persons who live under this model of policy express more distress related to financial concerns.

There are considerable variations within the income/asset-based policy model that could impact favourably on the situations of individuals. For example, in New Brunswick, the consideration of only 10% of assets per year may well mean that persons whose assets are bearing income will not see these depleted quickly; annual interest income of investments will form a portion of the 10%. In Newfoundland, a married woman who places her spouse in a nursing home may be at an advantage if she has a limited pension, because the rules there would allow her to access some of her husband's pension to regain her usual standard of living.

Other Variations in Access

Several other issues were raised that were not specific to one funding policy model. These did, however, impact on access to care.

Wait list management. There is considerable variation in the ways in which wait lists are managed. Some provinces have very long wait lists, British Columbia and urban Ontario having some of the longest (well over 1 year). Some provinces manage their wait lists by chronology and others by needs-priority. Those who have long lists and manage their lists by needs-priority commented that the low-needs individuals have to manage with family or community help, often for several months, even though they have been assessed as requiring more than these supports can offer.

Some communities have first available bed policies that require or encourage persons admitted to nursing homes from hospital to take the first available bed in a facility that is not their choice. While they can move to a preferred facility later, the situation creates multiple moves and difficulty for spouses or family members who are unable to get to the temporary location, which might be at a great distance (over 100 km).

Extra costs of care. In different provinces, the costs of transportation (such as ambulance), equipment, and supplies are handled differently. Some provinces provide greater equipment subsidies than do others. The costs of supplies and other items may be borne by family members if most of an individual's income is going to care costs. Comfort allowances (see Table 1), which are the amount of money available to the person in a nursing home after their income has been applied to care costs, are very low and have remained unchanged in many jurisdictions for a decade or more. This means that for the low-income person, the comfort allowance will be all the money he or she has available towards purchase of reading material, cigarettes, toiletries, television, telephone calls and other amenities.

Alternatives to nursing home care. There is enormous variation across the country as to the type and amount of respite care, home care, and residential care available. Some key informants stated that appropriate alternatives could delay the need for nursing home care. For example, one key informant believed that reductions in their home care budget—a result of regionalization of health care and pressures to provide a similar amount of service to other regions—was causing elderly persons to need nursing home placement sooner.

In some provinces, home support is means tested, while in others, a number of hours per month are provided without cost to the individual. The maximum amounts of care or subsidy available, and the levels of means testing, are also highly variable. Amounts and costs of care will influence the length of time a frail or disabled elderly person can live in his/her community before nursing home care is required. They may also impact on the income and assets available to persons at the time of placement. In some provinces, income and assets may be severely depleted by the time the person seeks nursing home placement. This might in turn affect a spouse remaining in the community after placement of his/her significant other, because he or she will be left with even fewer assets.

In some provinces, “residential” care (care that provides accommodation and meals but very limited personal care) is subsidized, while in others it is not. When it is not, it is often seen as a more expensive alternative because the person’s personal contribution to care may be higher than their contribution to nursing home care. Conversely, persons responsible for the full costs of their nursing home care might try to “make do” with a residential level of care because it is cheaper than nursing home care.

Key informants also noted that there are few alternatives between the “residential” level of care– in which the person must do a great deal for him or herself– and the “nursing” level of care– in which the person becomes almost totally dependent on others. The need for supportive living alternatives, which provide a high level of supervision but allow persons to be maximally involved in day-to-day activities, was mentioned as desirable by key informants.

Universality, Accessibility, and Comprehensiveness of Nursing Home Care in Canada

Universality. In considering the principle of universality regarding nursing home care, we can ask: is nursing home care equally available to all Canadians? The answer is yes, if we consider that there are mechanisms in place to ensure that all Canadians who need nursing home care have it, regardless of ability to pay. However it is not “equally available” if we consider that significant waiting times exist in certain parts of Canada. Waiting lists are affected by many factors other than the number of persons waiting, such as the presence of alternative forms of care. Another difficulty is that persons with particular problems, such as behaviour problems, might technically be entitled to care, but unable to access it in a timely manner.

The kinds of universality issues faced by persons needing long term care are faced by persons who require other forms of care that are limited, including many acute care services. However, the issue of waiting is critical in the case of nursing home care. Persons who are waiting for such care are waiting not just for health care services, but for a place to live, support services, and appropriate supervision. In the meantime they must “make do” and making do often taxes family caregivers and community services. Making do also often raises significant safety concerns. If we indeed have the right to “life, liberty, and security of person” as our Charter states, and we continue to limit the available number of nursing home beds, then we need to work as a society to provide safe forms of shelter, care and service to elderly persons who need them.

Accessibility and Comprehensiveness. The entire first section of Part B highlighted access issues. However, in considering the principle of accessibility of nursing home care, there are two types of issues that seem particularly important in the Canadian context. First there are the issues related to differences in the personal costs of nursing home care. Second, there are the differences that contribute to the hardship related to personal costs, such as marital status and gender.

As has been demonstrated, there are significant differences in personal contributions to the costs of nursing home care. The three policy models represent three different sets of values when it comes to the provision of nursing home care. In all three policy models, there is a reflection that persons should pay for their “room and board” costs: their shelter, food, and related services.

Underlying the per-diem policy model is the belief that all persons should bear the same cost. The costs are set so that persons with basic Old Age Security and Guaranteed Income Supplements can afford the costs of basic accommodation and be left with a small comfort allowance. Those who have access to higher pensions have the option of accommodation that affords more privacy.

Underlying the income-based policy is the belief that persons should contribute to their room and board costs to the best of their financial ability. In this model, subsidies are available, or rates are scaled, based on income. Again, those with more resources can usually upgrade to private accommodation. Both of these models presume that the specialized care costs associated with nursing home care constitute costs that should be absorbed publicly. This is in keeping with the spirit of the Canada Health Act, which insures “medically necessary” services.

In contrast, the income/asset-based policy model is based on the premise that citizens should pay the full costs of their nursing home care. This policy model does not support the idea that “illness is burden enough in itself” as described by Justice Hall. In other words, while the other two policy models support the idea that persons should pay their own day-to-day costs, this one asserts that persons should also pay for their own medical misfortunes. Not all elderly persons require nursing home care. In this policy model, those who do--persons who are extremely frail, ill, have dementia, and/or are physically disabled--are responsible for their own health and supportive care costs, as well as room and board costs. This is rather startling in a society in which persons are not usually held financially responsible treatment for illness, even those illnesses clearly linked to lifestyle.

While this philosophy might be pragmatic in provinces that are short of funds, it is certainly not in keeping with the principles of the Canada Health Act. It is also not in keeping with the spirit of the Charter of Rights, in particular the principle of protection from discrimination based on age, mental or physical disability. This is an issue not just of differing access but of comprehensiveness. How is it that health care delivered in an acute care facility, or nursing care delivered in the home, or health promotion services delivered in a community health centre can be insured or publicly funded, while nursing care delivered in a nursing home is not?

The income/asset-based policy model poses other, albeit indirect, challenges to accessibility, and certainly creates a placement experience that is far different from persons living in regions with other policy models. Many of these access issues become visible if we take the standpoint that nursing home placement is usually a process undertaken by families, rather than individuals. Thus there are parts of this process that can cause inequities for spouses and other family members. For example, in the case of married couples, the placement of one individual in a nursing home will leave the community-dwelling spouse in a financially disadvantaged position. Despite admirable policy initiatives by provinces such as Newfoundland³ to counteract this, the expenses of the community-living spouse do not change markedly and may actually increase. Community dwelling spouses living in regions with this policy model also face difficulties regarding their dwelling. The family home is exempted from assets in the calculation of personal contributions to nursing home costs. However, if the spouse sells the home because he or she cannot afford upkeep or taxes, or cannot manage maintenance, the home becomes an “asset” and one half the selling price will be applied to the cost of nursing home care. The spouse then only has half the money to invest in rent or a more appropriate dwelling.

The income/asset-based policy model also creates a great deal of stress for spouses or other family members, who must amass the information required for the financial assessment. During the placement process, frequently described by spouses and family members as the most stressful process of their lives, another layer of invasiveness and stress is added. In some provinces such as New Brunswick, if family members decide they do not wish to participate in the financial assessment, they are free to pay privately for care. In Nova Scotia, if families do not wish to participate in the financial assessment, they must declare that they will never approach the government for assistance with nursing home care costs. The process of financial assessment can be lengthy as well as difficult, owing to the need to retrieve financial records and receipts. So long as families cooperate with the assessment, nursing home placement can occur even if it is not complete. However, if the family does not cooperate with the assessment, nursing home placement can be delayed.

³In 1999, Newfoundland made changes to their legislation regarding the amount of a couple's income that had to be applied to the cost of care. Previous to the change, the income of each individual was applied to the cost of care and the community-dwelling spouse could not have access to any portion of his/her partner's federal pensions. This usually disadvantaged women who were less likely to have Canada Pension Plan income. The policy change allowed the community-dwelling spouse to keep a base amount of income and explicitly outlined several additional items which could be funded from her partner's income, such as medical expenses, loan repayments, home maintenance and transportation costs, and memberships to clubs (key informant personal communication, 2001).

This policy model affects women and men differently. On the one hand, because women tend to live longer than men, more men who are placed in nursing home care are married rather than widowed. It is often female spouses who are left to manage in the community with reduced income and assets. On the other hand, women are more likely to live to the age at which nursing home care is needed (about 40% of people over age 85 will require nursing home care). Because women are less likely to have participated in the workforce to the same extent as men, they are more likely to require subsidies for care and thus to go through the financial assessment process. They are also more likely to completely spend down their assets.

Finally, this policy model also disadvantages those elders who have carefully saved their entire lives, while their cohorts spent their disposable income. While it is common for elderly persons to express the desire to “pay their own way,” many feel cheated that they cannot leave a legacy for their children. A counter-argument is often made that the children want to “hold on to the money” of their parents, rather than using it to pay for nursing home care. However, the question remains: why should some Canadians have to use their assets to pay for their nursing home care when others do not? And why should some Canadians have to spend their assets on care they require due to a disability or health care problem?

Difficult decisions remain to be made about our long term care system, of which nursing home care is a part. With current economic pressures and moves towards increasing private responsibility for health care, there is a danger that in the future, more provinces will move toward an income/asset-based model. I would challenge Canadians to think about the principles behind such decisions, and the appropriateness of “personal responsibility” for all health costs. My critique of the income/asset-based policy model does not imply that nursing home care under such a model is in any way compromised. My intent is rather to draw attention to the ways in which this policy model deviates from the principles of accessibility and comprehensiveness, and the rights espoused in our Charter.

Part 3. Trends and Solutions

“Right now in Nova Scotia it looks like a very non-caring society [the] way we’re doing it...and that bothers me a great deal because that’s not the Nova Scotia way.”

Key informant, Nova Scotia

From the pilot study, there seemed to be general agreement across the country on the following points:

- persons should be responsible for their own room and board costs of care;
- persons who are unable to afford the costs of care should be publicly funded;
- it would be beneficial to have a similar system of personal contributions to the costs of nursing home care across the country.

There is considerable divergence of opinion by province as to whether persons should pay for the “special care” portion of nursing home care– the portion related to the special health needs of persons who are extremely frail, ill, have dementia or physical disabilities. I have argued in the previous section that requiring Canadians to pay for this portion of nursing home care is not in the spirit of the principles of medicare, nor is it in the spirit of the Canadian Charter of Rights and Freedoms.

However, it must be recognized that the costs of nursing home care are substantial and provincial health care systems are unable to handle increased costs. There is a shortage of funds for the current levels of publicly-funded health care and despite the rhetoric about “spending wiser,” there is still the question of whether this would result in enough money, and also whether funding nursing home care would be a priority.

While both the Kirby Review and the Romanow Commission preliminary reports recognize the difficulties caused by provincial differences in long term care services, their over-arching concern is how to deal with health care costs. The Kirby Review recognizes the issue of funding health services for elderly persons, particularly those in the “baby boom”, and proposes several strategies:

- a Senior’s Health Grant, as part of the Canada Health and Social Transfer payments, presumably funded by taxing current workers for their future health care;
- a “loss of autonomy fund” financed through employer and employee contributions, operating in much the same way as a pension fund;
- innovations such as Laurier House in Edmonton, Alberta, in which the nursing home residents actually own their own condominium in a care facility. In addition they pay a board and service cost, while care costs are publically funded (Kirby, 2002, p. 16).

The difficulty with the first two solutions is that they depend on people being in the workforce to make their contribution. Presumably the money would go into a general fund to be accessed later by all who require it, but this is not made clear. The third solution is one that might work well for persons who are mid-income, have sufficient assets, or have children who can assist in buying the accommodation, but is not a viable solution for seniors in poverty or those who never owned their homes. The amount of privacy in such a solution is appealing but the level of supervision available to the resident who has a need to be monitored for safety reasons, such as the person with dementia, is questionable (site tour personal communication, 2000).

Both reports also frankly discuss funding solutions that would result in changing our current reliance on a single-tiered, publicly administered system. With the direction that the two Canadian reviews are taking, it would not be surprising to see private long term care insurance and other self-funded options proposed as solutions to the funding of nursing home care.

There are other social forces pushing towards increased self-funding of long term care. Clark (1991), McKeever (1996), Montgomery (1999) and others have noted the prevalence of “familism” when the care needs of elderly persons are considered. The primacy of the family is seen as natural, and care, when needed, is the domain of women (children or spouses). Nursing home placement can be construed as a failure of the family and therefore a personal responsibility for that family to bear. Clark writes about the American system in this manner, contrasting it with a Canadian social welfare approach of sharing the burdens resulting from illness and disability. However it should be noted that the American nursing home funding system is remarkably similar to the income/asset-based policy model seen in Eastern Canada, wherein persons pay their own nursing home costs until their assets are depleted, and only then can they apply for public funding. The notion of familism can be seen in Canadian policy surrounding home care, respite care, and caregiver support.

There are also tensions between medicalization and socialization of nursing home care (Havens, 1995; Merrill, 1992; Shapiro, 2000). The tendency in the past has been to medicalize long term care, to focus on the medical needs of persons requiring it, to give primacy to medical routines (medications, rounds, “bed” counts). This tendency towards medicalization fits well with the Canada Health Act as it stands. However, the rhetoric of nursing home care policy all across Canada has shifted to a more social model of care in which the focus is on quality of life issues and support, rather than care (for example, Keating et al., 1998). With this shift comes a possible consequence. Social services, while often publically-supported, have traditionally been means- tested in Canada. The definition of nursing home care as social may well serve to push it further away from public funding. There is some conjecture that the reason the western part of Canada funds some or most of nursing home care while eastern Canada does not relates to a longstanding historical alliance in Atlantic Canada of nursing home care with social services.

Ageism and anti-institutionalism might not directly contribute to a policy shift to self-funded care, but they do serve to lower the priority of the nursing home care funding issue. Frail elderly people are seen as heavy consumers of health services and a drain on health spending (Gee, 2000). Aged individuals, particularly those needing long term care, are seen as less worthy of health care spending because their outcomes are not likely to be as positive. The recent focus on “successful aging” may actually detract attention from elderly persons being seen to age “unsuccessfully” as evidenced by their placement in a nursing home (Rowe & Kahn, 1997). The emphases on community care and deinstitutionalization have long been recognized as a way to shift responsibility for care away from the health sector and back onto families (McKeever, 1996). The benefits of nursing home admission, particularly for elderly people who are socially isolated or mobility-impaired, are seldom discussed.

The question remains of how persons who cannot afford long term care would be able to afford long term care insurance. Indeed the whole premise of long term care insurance is that the needs of the poor will still be covered by the state, while the middle class will increasingly pay for their needs. In the United States, it has been found that people are reluctant to buy long term care insurance because of its cost and the feeling that it will not be needed (Kassner & Shirey, 2000; Merrill, 1992). A variety of incentives to purchase insurance have been proposed, including mechanisms akin to registered retirement savings plans, tax subsidies, “front end” public coverage (coverage up to a certain dollar value), “back end” coverage that allows persons to self-insure to a maximum value after which public funding is available, and insurance for asset protection. Life care communities, in which one purchases accommodation plus a service contract for future health care needs, offer another alternative to self-fund or pre-fund long term care.

In the short run, publicly- subsidized insurance incentives might be a good compromise in jurisdictions with policies that require citizens to contribute to the full cost of care. However, as Merrill (1992) warns, we must be careful to remember that nursing home care is a care program to meet the needs of a frail population, rather than a health benefit that pays providers. The issue must not become “how can we make it possible for persons to pay for this service” but rather “what services are needed by our citizens and how might these be supported in a fair and equitable manner?”

The Romanow Commission preliminary report frames the four possibilities for dealing with the challenges of our health care system: more public investment, shared costs and responsibilities, increased private choices, and reorganized service delivery. I would suggest that when these challenges are considered, we must ponder them not just financially but ideologically. How can we continue to support the fundamental principles of medicare that Canadians take pride in? How can we ensure that rights and freedoms are respected and that vulnerable persons are not disadvantaged by our health care systems?

Those who work in long term care, and families who use it, know that part of the way to increase accessibility is to reorganize service delivery in the whole long term care sector, so that real choices for care, shelter, supervision, and support are available to citizens. I believe that Canadians are also willing to share costs and responsibilities of nursing home care, by contributing to the best of their ability to room and board costs. The public share of responsibility is in ensuring that citizens are not being penalized for their health status by having to pay for the specialized health care portion of nursing home costs. Canadians must be prepared to look at mechanisms to provide funds for an equitable public investment in nursing home care across the country. Much will depend on the value we place upon publicly-funded health care that is truly universal, accessible, and comprehensive over the whole life span. Much will depend on the value we place on elderly Canadians.

Table 1. Comparisons Related to Personal Contributions to Nursing Home Care Costs, Provinces and Territories

	Means testing	Couples treatment	Per diem	Comfort allowance (minimum)	Residency requirement
BC	Yes Income	Incomes combined and half applied	\$25.60 - \$50.00 (WGCC, 2000)	Minimum of 15% of income is retained	1 year in BC Canadian citizen or permanent resident
Alberta	No		\$24.75 (standard room) \$26.25 semi \$28.60 private (WGCC, 2000)		10 years in Canada and 12 months in Alberta, or resident in Alberta 3 consecutive years during lifetime
Saskatchewan	Yes Income	Incomes combined and half applied	\$805-\$1516 per month (26.46-49.84) (personal communication)	\$161	None
Manitoba	Yes Income	Each can apply to retain own income	\$25.10-\$58.60 (WGCC, 2000)	\$100	Canadian citizen or 24 month waiting period after becoming Manitoba resident
Ontario	Yes Income	Incomes combined and half applied	\$42.01 basic \$50.01 semi-private \$60.01 private government subsidy available if unable to pay (WGCC, 2000)	\$112	Ontario health card
Quebec	Yes Income	n/a	n/a	n/a	n/a
Nova Scotia	Yes Income and assets Bank statements and income tax returns examined 3 years back for evidence of divestment	Income and assets combined and half applied; \$5000 exempt; individual exceptions also apply	Pay as much as able up to full costs; remainder subsidized by province Rates individually set for each nursing home, Approx \$75 to \$160 (personal communication)	\$105	Resident of Nova Scotia

Prince Edward Island	Yes Income and assets Statements examined 2 years back	Income and assets halved; \$5000 exempt; individual exceptions also apply	Pay as much as able up to full costs; remainder subsidized by province \$82-116 private \$107 public (WGCC, 2000)	\$82	Resident of PEI for last 12 months Canadian citizen or permanent resident Or have PEI Health card
New Brunswick	Yes Income and liquid assets Statements examined 2 years back	Total couple income and assets examined and then a formula applied; results in approx 60% of income retained by spouse and approx 10% of assets per year being applied to cost of care.	Pay as much as able up to full costs; remainder subsidized by province Level 3 \$105/day Level 4 \$134/day (personal communication)	\$88	NB resident with health card
Newfoundland	Yes Income and liquid assets Statements examined 1 year back	Each spouse retains own income; can apply to access income of placed partner if needed for expenses; \$750 plus 20 explicit expenses allowed. Explicit policy to retain former standard of living for community dwelling spouse.	Pays as much as able, remainder subsidized by province to maximum \$2800/ mo (\$92.06/ day) (FGCC, 2000)	\$125	Nfld resident
Yukon	No	n/a	\$18-\$21 (FGCC, 2000)		1 year
Northwest	No	n/a	\$712/ mo (\$23.41/day) (FGCC, 2000)		Non-residents may be admitted if they pay extra for first 3 months NWT health card
Nunavut n/a					

Source documents: Alberta, 1999; WGCC, 2000; personal communications with some provincial Health departments

Table 2. Examples of three models of policies regarding personal contributions to nursing home care costs in Canada

Policy model	Per diem	Income-based	Income/asset-based
Example	Alberta	Manitoba	Nova Scotia
Means tested (income)	no	yes	yes
Means tested (assets)	no	no	yes
Personal contribution to costs (explanation)	Based on usual pension amounts available to individuals (excluding CPP and private pensions). Meant to contribute to room and board costs of care.	Based on reported income on previous year's income tax return. Income of couples is combined and fee is set based on half combined income. Case by case adjustments for expenses of community-dwelling spouse, dependents, etc. are made. Meant contribute to room and board costs of care.	Based on income and assets. Financial records are reviewed for 3 years prior to application date to ensure that assets have not been "divested." Income of couples is combined and fee is set based on half combined income and assets. Case by case adjustments for expenses of community-dwelling spouse, dependents, etc. are made. Meant to contribute to full costs of care.
Personal contribution to costs (1999 rates)	\$24.75 to \$28.60 per day	\$25.10 to \$58.60 per day	\$75.00 to \$160.00 per day but subsidy is available for those who cannot afford these rates. Income and assets must be spent down before subsidy is applied.

Source documents: Alberta Health and Wellness, 1999; FGCC, 2000; Stadnyk, 2001

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