POPULATION AGING AND LONG-TERM CARE POLICY CHANGE IN CANADA: A COMPARISON OF BRITISH COLUMBIA, MANITOBA, AND ONTARIO

A Thesis

submitted to the Faculty of Graduate Studies and Research

in partial fulfillment of the requirements

for the Degree of

Master of Public Policy

in Health Services Research

University of Regina

By

Jonathan Brody Harris

Regina, Saskatchewan

November, 2014

Copyright 2014: J.B. Harris
Jonathan Brody Harris, candidate for the degree of Master of Public Policy in Health System Research, has presented a thesis titled, *Population Aging and Long-Term Care Policy Change in Canada: A Comparison of British Columbia, Manitoba, and Ontario*, in an oral examination held on November 4, 2014. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

External Examiner: Dr. Rebecca Genoe, Faculty of Kinesiology & Health Studies

Supervisor: Dr. Gregory P. Marchildon, Johnson-Shoyama Graduate School

Committee Member: Dr. Amy Zarzeczny, Johnson-Shoyama Graduate School

Committee Member: Dr. Haizhen Mou, Adjunct

Chair of Defense: Dr. Joseph Piwowar, Department of Geography

*via video conference*
Abstract

**Introduction:** Residential long-term care (LTC) is an important component of the care continuum for older adults in Canada. Three factors related to population aging are contributing to an increased demand for LTC services: 1) an increased prevalence of age-related health disorders; 2) reduced societal capacity to provide unpaid care; and 3) a lack of available substitutes for LTC. LTC is not one of Medicare’s insured services and as such great variation in the provision of LTC services exists across provinces. Provincial governments are currently grappling with how best to provide and pay for quality LTC services while also weighing investment in other aspects of the care continuum to delay or prevent LTC admission.

**Purpose:** The purpose of this thesis is to examine LTC policy changes since 1990 and the impact these have had on LTC spending and quality in three provinces that represent natural policy experiments: British Columbia, where a disinvestment in LTC and concurrent investment in assisted living has taken place; Manitoba, one of the largest per capita spenders on both LTC and home care; and Ontario, which has essentially maintained the status quo.

**Methods:** A retrospective comparative case study approach adapted from the work of Richard Rose (2005) is used to compare provincial experiences. Evidence was drawn from a comprehensive literature review of not only peer-reviewed literature but also grey literature, including policy and planning documents and advocacy group and think-tank reports. Descriptive analysis was performed on spending data obtained from the Canadian Institute for Health Information’s National Health Expenditures Database, and Quality data obtained from the Canadian Institute for Health Information’s Continuing Care Reporting System.
**Results:** British Columbia’s strategy of investment in assisted living in lieu of LTC resulted in substantial cost savings since the early 2000s. LTC quality was best in Manitoba, where the per capita spend on LTC is highest, although resident populations varied slightly between provinces.

**Conclusions and Recommendations:** While British Columbia has successfully reduced costs in the LTC sector by substituting assisted living, there is some evidence to suggest that this approach may create barriers to access and lead to downward pressures in other parts of the health system, particularly acute care. Investment in a robust continuum of care that includes support for informal carers, home care, respite care, assisted living, and LTC where appropriate seems the best way to meet the needs of the aging population while providing affordable and high quality LTC. Additionally, paradigms such as aging in place, although well-intentioned, may be misused by governments to achieve policy ends and can be a barrier to effective reform in the LTC sector.

**Keywords:** Long-term care, continuing care, aging, health policy, health services.
Acknowledgements

Funding for this research was provided through a studentship of the Western Regional Training Program for Health Services Research and Enhancement Awards from the Faculty of Graduate Studies and Research, University of Regina.

First, I must extend my most sincere thanks to my supervisor, Dr. Gregory Marchildon. Greg, you have introduced me to new ways of thinking and constantly pushed me to be better. Your trust and encouragement have meant more to me than you will ever know.

To my committee, Dr. Amy Zarzeczny at the University of Regina, and Dr. Haizhen Mou at the University of Saskatchewan, and my external examiner Dr. Rebecca Genoe, thank you for your valuable insights in crafting the final version this thesis.

To my mentors, Dr. Shanthi Johnson at the University of Regina and Dr. Angie Kolen at St. Francis Xavier University: I take the lessons I have learned from each of you everywhere I go. Your compassion and commitment to service is a constant source of inspiration and has informed this work.

To John Wright, my mentor during my internship at the Canadian Institute for Health Information: Thank you for being so generous with your time, expertise, and wisdom. In a short time, you taught me so much about being an effective and principled leader and your input was vital in shaping the direction of this work.

To my fellow graduate students and friends from the University of Regina, especially Michael Goldberg, Sebastian Harenberg, Erwin Karreman, Kimberly Hill, Miranda Brown, Adam Mills, Sharon Bishop, Caroline Beck, and Olena Kapral, thank you for your support, guidance, and assistance.
Dedication

To Mom, Dad, and Rebecca, I am externally grateful for your patience, support, and love.
Table of Contents

Abstract .......................................................................................................................... i

Acknowledgements .................................................................................................. iii

Dedication ................................................................................................................ iv

Table of Contents .................................................................................................. v

List of Tables .......................................................................................................... viii

List of Figures .......................................................................................................... ix

Chapter 1: Population Aging and Long-Term Care Demand ..................................... 1

Introduction .............................................................................................................. 1

Range of Continuing Care Services ......................................................................... 4

Increasing Demand for Long-Term Care .................................................................. 9

Policy Problem ......................................................................................................... 13

Research Questions .................................................................................................. 14

Methods .................................................................................................................... 14

Chapter 2: Long-Term Care Policy Context in Canada ........................................... 18

Historical Context .................................................................................................... 18

Current Policy Context ............................................................................................ 21

Future Needs ............................................................................................................. 26

Quality ...................................................................................................................... 27

Conclusions .............................................................................................................. 30

Chapter 3: Long-Term Care Policy Cycle and Options ............................................ 31

Agenda Setting ......................................................................................................... 33

Multiple Streams in Canadian Long-Term Care Policy .......................................... 34

Problem Stream ...................................................................................................... 34
Policies Stream ............................................................................................................ 36
Political Stream ......................................................................................................... 46
Policy Formulation ..................................................................................................... 53
Decision Making .......................................................................................................... 55

Chapter 4: Policy Directions in British Columbia, Manitoba, and Ontario ............. 58
British Columbia .......................................................................................................... 59
Manitoba ....................................................................................................................... 63
Ontario .......................................................................................................................... 65
Comparison ................................................................................................................... 68

Chapter 5: Long-Term Care Spending Trends ......................................................... 74
Analysis .......................................................................................................................... 88

Chapter 6: Quality of Care in Long-Term Care ....................................................... 90
Data Source ................................................................................................................... 92
Comparing Provincial Resident Profiles ...................................................................... 93
Indicator Selection ......................................................................................................... 94
Physical Function .......................................................................................................... 95

Maintained ability to transfer, walk, or wheel ............................................................. 95
Worsened bladder continence ...................................................................................... 97
Quality of Life ................................................................................................................ 99
Depression ..................................................................................................................... 99
Worsened behavioural symptoms .............................................................................. 101
Worsened pain .............................................................................................................. 103
Safety ............................................................................................................................ 105
Falls .......................................................................................................................... 105

Inappropriate use of antipsychotic medications ............................................. 107

Pressure ulcers ...................................................................................................... 109

Conclusions ............................................................................................................. 111

Chapter 7: Conclusions and Policy Recommendations ..................................... 115

Summary of Provincial Experiences ................................................................. 115

Limitations ............................................................................................................. 117

Aging in Place Philosophy .................................................................................. 117

Policy Recommendations .................................................................................. 119

Future Research Directions ............................................................................. 124

Conclusions ............................................................................................................. 125

References ............................................................................................................. 128
List of Tables

Table 2.1 Provincial LTC Subsidy Approaches.................................................................25
Table 2.2. LTC Quality Indicators .....................................................................................29
Table 4.1. A comparative model for continuing care programs in British Columbia, Manitoba, and Ontario. ........................................................................................................70
Table 4.2. An overview of assisted living frameworks in British Columbia, Manitoba, and Ontario. .........................................................................................................................71
Table 6.1. Summary table of top provincial performers on each quality indicator........112
List of Figures

Figure 1.1. Continuing care continuum in Canada..........................................................7

Figure 3.1. The public policy cycle. .................................................................................32

Figure 5.1. Per capita total expenditure (public and private) on Other Institutions, 1990-
2013. ...............................................................................................................................76

Figure 5.2. Provincial government expenditure on Other Institutions, 1990-2003 ............78

Figure 5.3. Private expenditure on Other Institutions, 1990-2013. ..............................80

Figure 5.4. Provincial government vs. private expenditure on Other Institutions, Ontario,
1990-2013. .....................................................................................................................82

Figure 5.5. Provincial government vs. private expenditure on Other Institutions,
Manitoba, 1990-2013 ......................................................................................................83

Figure 5.6. Provincial government vs. private expenditure on Other Institutions, British
Columbia, 1990-2013. ....................................................................................................84

Figure 5.7. Percent of total provincial government health spending on Other Institutions,
1990-2013. .....................................................................................................................86

Figure 5.8. Percent of total provincial government health expenditure on hospitals, 1990-
2013. ...............................................................................................................................87

Figure 6.1. Maintenance or improvement in transfer, wheeling, and walking ability, 2011-
2012. ..................................................................................................................................96

Figure 6.2. Percentage of residents with worsened bladder incontinence, 2011-12 ...........98

Figure 6.3. Percentage of residents with worsened mood from symptoms of depression,
2011-12. ..........................................................................................................................100

Figure 6.4. Percentage of residents with worsened behavioural symptoms, 2011-12. .........102
Figure 6.5. Percentage of residents with worsened pain, 2011-12. .................................................104

Figure 6.6. Percentage of residents who had fallen in the past 30 days, 2011-12. .........................106

Figure 6.7. Percentage of residents with inappropriate use of antipsychotics, 2011-12. ..............108

Figure 6.8. Percentage of residents with a new stage 2-4 pressure ulcer, 2011-12.......................110
Chapter 1: Population Aging and Long-Term Care Demand

Introduction

Older adults, defined as those aged 65 years and older, are the fastest growing segment of the Canadian population, comprising 15.7% of the Canadian population as of July 1, 2014. The first members of the post-Second World War baby boom generation to turn age 65 did so in 2011, and as this demographic shift continues, the proportion of older adults will continue to rise across Canada. By 2063, it is estimated that between 24 and 28 percent of Canada’s population will be aged 65 and older (Statistics Canada 2014a).

Evidence suggests that throughout the developed world, not only are people living longer, but are doing so in better physical and cognitive health (Christensen et al. 2013). Although a high proportion of Canadian older adults report living in good health well past the age of 65, more than 25% are limited in their ability to perform activities of daily living due to chronic or age-related health conditions (Health Canada 2002). Older adults also have much higher rates of health service utilization, prescription medication use, hospitalization and institutionalization than their younger counterparts (Health Canada 2002). Most of those over the age of 65 have at least one chronic health condition, and age is the main independent risk factor for a variety of diseases, including cancer, cardiovascular disease, and neurodegenerative conditions such as dementia (Niccoli and Partridge 2012).

This unprecedented rate of population aging has created a substantial policy problem for Canadian provincial governments, who continue to grapple with how to provide the most appropriate and cost-effective health care for seniors. Older adults are heavy users of physician and acute care services relative to other population segments.
(CIHI 2011a), but these services are only part of the necessary care continuum needed to support health throughout the aging process. However, the policy legacies of Medicare and the Canada Health Act have resulted in a “tyranny of the acute”; a system that is built around hospital and physician services and, in many ways, better equipped to deal with the acutely ill than those with multiple sub-acute comorbid health conditions. Older adults commonly suffer from chronic health conditions for which there is no cure and that primarily require long-term, non-physician care. These needs are sometimes not well addressed in a system structured to deal with patients with acute care needs (Chappell 2011). Lewis and Sullivan (2013, p. 6) describe the organization and financing incentives of the Canadian health system as follows:

When a frail elderly person walks into an emergency room with an impending heart attack, the system is instantly primed to spend tens of thousands of dollars for tests, surgery and a hospital stay. However, that is often the same person who languished at home, mildly depressed, isolated, physically inactive and malnourished — someone for whom the system refused to spend a few hundred dollars a month on home care to prevent the catastrophe that ended up in the emergency room and the operating room.

Indeed, the principles of the Canada Health Act (accessibility, portability, universality, comprehensiveness, and public administration) apply only to insured hospital and physician services and not to other “extended health services”, as they are termed in the Act itself (Canada 1984). While terminology varies across the country, a 2009 report by the Canadian Health Care Association uses the term continuing care to describe “an integrated mix of health, social and support services offered on a prolonged basis, either intermittently or continuously, to individuals whose functional capacities are at risk of impairment, temporarily impaired or chronically impaired” (Canadian Healthcare Association 2009). Provision of continuing care, which includes the core
services of home care, community support services (e.g. day/respite programs), assisted living, and facility-based long-term care (Canadian Healthcare Association 2009), is determined by the provinces and funded through general taxation and, to a limited extent, by the federal Canada Social Transfer. The Canada Social Transfer provides broad funding for social programs (e.g. subsidies for care) but does not expressly stipulate that these funds be used for continuing care (Gauthier 2012). Because continuing care services are not insured under the Canada Health Act, user fees can be imposed and their provision varies greatly from province to province, as do the income-tested subsidies citizens are eligible for (Cool 2012). While all provinces and territories fund core continuing care services, access, quality, copayments, and the ratio of public to private provision vary greatly across the country (CFHI 2011).

The legal distinction between hospital and physician services and “extended health care services” (including continuing care) as set out in the Canada Health Act is well understood in health policy circles. However, this understanding sometimes does not extend to the public at large. Public perception of “free” and universal health care leads many Canadians to expect that a robust, publicly-administered continuing care system exempt from user fees awaits them as they grow older. Even among those who understand that the Canada Health Act principles do not extend to non-physician, non-hospital services, the high cost of continuing care (and particularly facility-based long-term care) to users can be surprising. This expectation gap can leave many Canadians and their families financially and emotionally unprepared to navigate an increasingly complex and burdened continuing care system.
Policy shifts in the 1990s resulted in many provincial governments prioritizing home care over residential long-term care (Keefe 2011). This was likely a result of fiscal constraints created by cuts to federal transfer payments for health in combination with growing philosophies of deinstitutionalization and care delivered in the community. However, residential long-term care remains a substantial part of the Canadian health system, accounting for an estimated $20.8 billion in spending in 2011, representing 10.4% of total Canadian health spending (CIHI 2013a). A 2007 Statistics Canada survey showed that there are 4291 long-term care facilities in Canada, with nearly 236,000 residents in total. Older adults make up the vast majority of long-term care residents, and this will continue to be the case as the current demographic shift unfolds (Statistics Canada 2007).

**Range of Continuing Care Services**

Residential long-term care, which is defined as health care provided to residents of care facilities licensed by provincial departments of health by recognized health professionals (CIHI 2002), is only part of the care continuum for older adults. A diagram showing the typical continuum, from least to most labour- and resource-intensive care is presented in Figure 1.1, although it should be noted that the care options presented are not universally available across the country and include services that are privately financed in addition to those subsidized by government.

The vast majority of Canadian older adults (~93%) live at home (CIHI 2011b), and, as previously noted, the majority of these individuals live independently in good health, and access services such as primary care and acute care on an ad-hoc basis. When older adults living in the community require assistance with day-to-day living, they often
turn first to informal carers such as family members (particularly spouses and adult children) and friends. Evidence suggests that older adults prefer to be cared for in the home and informal caregivers often want to take on the role of providing care to their relative or friend (Hollander, Liu, and Chappell 2009). It is estimated that between 70 and 80 percent of care in the community is informal and provided by family members or friends (Hébert et al. 2001; Lafrenière et al. 2003).

Formal home care services are often accessed as an adjunct to informally provided care, or when there are no informal caregivers available (Chappell 2011). An estimated 1.2 million Canadians access formal home care services annually (Carrière 2006). Home care services include supportive services such as housekeeping, laundry, and meal preparation, personal care assistance which is often provided by unregulated providers (e.g. personal support workers, special care aides) (Kehoe-MacLeod 2012), and active treatment provided by physicians, nurses, and other allied health professionals. Access to these services varies from province to province and between urban and rural residents. Some provinces, such as New Brunswick and Manitoba, have invested heavily in comprehensive public home care programs while others rely more on private providers and provide subsidies to clients.

For older adults with higher care needs residing at home, respite or convalescent care is sometimes used as a means of delivering short-term, rehabilitative care or respite to informal caregivers. Respite care is usually provided in acute or long-term care facilities and is often viewed as a means of delaying entry to a residential care facility.

For older adults who require support in their daily activities but not around the clock care, assisted living (known as supportive housing in some jurisdictions) is an
option. Assisted living facilities often require a relatively high out-of-pocket pay component and, in most provinces, are not highly regulated by government. While models vary and there are few provincial and national standards for this emerging sector, most assisted living facilities offer accommodation and supportive services, such as housekeeping, meals, and transportation but do not offer 24-hour skilled nursing care (Golant 2002).

Residential long-term care (henceforth referred to as LTC), sometimes also known as nursing home care, can be defined as 24-hour available skilled nursing care received in a facility-based, long stay environment and is often thought of as the final stage of the care continuum. LTC has often been conceived of in research and policy circles as a care setting of last resort for the very frail or those without adequate social support networks. Indeed, individuals who reside in LTC facilities often end up there as a result of complex health needs that cannot be managed at home, or from an inability to access the necessary formal and/or informal supports to stay at home safely (Chappell 2011).
Figure 1.1. Continuing care continuum in Canada. (Source: Author)
Older adults who require care but do not have access to continuing care services such as formal home care are often admitted to hospital and are not discharged until appropriate community services can be obtained. This situation is referred to as alternate level of care (ALC), because the client does not require active medical care and would be more appropriately cared for in an alternate setting, such as at home or in LTC. This situation is sometimes also referred to as “bed blocking”, although this term is avoided in the formal literature likely because of the negative connotation toward older adults who are hospitalized through no fault of their own. A 2009 CIHI analysis using data that excluded the provinces of Manitoba and Quebec found that 14% of all hospital days in acute facilities were used by older adults designated as ALC and that on any given day, about 5200 Canadian hospital beds (outside of Manitoba and Quebec) were occupied by clients who could be better treated in another care setting. Given the estimated $59 billion spent on Canadian hospitals in 2011 (CIHI 2013a), this represents a large monetary cost in addition to the human costs of delaying entry to a more appropriate care setting. A follow-up analysis of CIHI’s 2009 work found that more than half of adults over the age of 65 who waited in acute care after active treatment was complete were discharged to LTC, and that these clients accounted for nearly 5 million ALC days between April 2007 and September 2011 (CIHI 2012). Persons with more complex care needs who did not have strong social support networks (including formal home care services and informal supports such as family and friends) were more likely to be discharged to LTC. In addition, individuals with dementia waited longer in acute care while awaiting admission to LTC, raising concerns about the availability of specialized care in appropriate settings
for this population (CIHI 2012). It has also been documented that waiting longer in an acute care bed may lead to declines in health and physical function (Graf 2006), further emphasizing the need for appropriate care settings and highlighting a potential access problem.

While it has been noted that some older adults designated as ALC awaiting LTC admission could be cared for at home with adequate supports (CIHI 2012), there are still many older adults for whom LTC is the best, or indeed the only, option. The staggering ALC statistics only further illustrate the rising demand for LTC services. It is not realistic or feasible to suggest that the care needs of all older Canadians can be met in the home, nor is it realistic to assume that the social and financial resources required for effective home care are equally available across the population.

**Increasing Demand for LTC**

LTC is the most resource intensive and costly care option for older adults. For this reason, it has been the focus of a great deal of government attention, in the form of expert commissions, reports, and policy reforms (e.g. Sharkey 2008). Some provinces, such as British Columbia, have aimed policy reforms explicitly at reducing demand for LTC through the substitution of less costly care options like assisted living. However, population aging is likely to increase demand dramatically in the LTC sector, calling in to question the extent to which such reforms can be effective.

I propose that three major issues will drive increased demand for long-term care during the current demographic shift. First, population aging will result in an *increase in prevalence of age-related disorders*. As previously noted, age is an independent risk factor for a number of health conditions. Although older adults in the developed world
are living longer and healthier lives, the longer any individual lives, the more likely she or he is to develop certain diseases. An illustrative example is dementia, a syndrome caused by disease of the brain that leads to a progressive decline in cognitive functioning, including deficits in memory, learning, orientation, language, comprehension, and judgement (Feldman et al. 2008). Dementia risk increases exponentially with age and is estimated to double about every five years after age 65. After age 85, the odds of developing dementia are nearly 50% (van der Flier and Scheltens 2005). According to a World Health Organization report on the global burden of disease, dementia is the second highest disease contributor to years lived with disability worldwide, contributing over 7.4 million years of dependence and disability among sufferers (Mathers, Fat, Boerma, World Health Organization, & Joint United Nations Programme on HIV/AIDS 2008).

As is evident by the high proportion of ALC days used for individuals with dementia, their unique care needs, particularly at advanced stages of the disease, often cannot be met in the home. Many require around the clock supervision and care which cannot, for a variety of social and economic reasons, be provided by informal carers. Further, because of longer life spans and the growing proportion of older adults, it is projected that both the incidence and prevalence of dementia will climb dramatically as the Baby Boom generation progresses through old age. In terms of incidence, the rate of new dementia cases in Canadians aged 65 and older is projected to rise from 103,728 per year in 2008 to 257,811 in 2038. In terms of prevalence, in 2008 it was estimated that there were 480,615 cases of dementia in Canada, representing 1.5% of the population. By 2038, this number is expected to grow to over 1.1 million cases, representing about 2.8% of the population. Based on current policies and utilization rates, the rising incidence and
prevalence of dementia are projected to result in a tenfold increase in demand for LTC services (Alzheimer Society of Canada and RiskAnalytica 2010).

It must also be noted that dementia is just one age-related health condition that drives LTC demand. A recent analysis using Statistics Canada’s LifePaths microsimulation model found that there will be an estimated 800,000 more Canadians aged 65 and older who are classified as experiencing moderate or severe disability or institutionalization in 2021 than there were in 2001 (Wolfson 2010). Thus, the tenfold increase in demand for LTC services as a result of dementia alone may be a substantial underestimate of the overall change in demand.

Second, downward trend in the societal capacity to provide unpaid care is underway. Consistent with other analyses, Keefe (2011) found that the number of elderly Canadians needing some level of supportive care will double over the coming 30 years, reaching a plateau around 2046. It is known that the amount of unpaid care provided is increasing, and an estimate using market rates for private home care and excluding the opportunity cost to caregivers estimated the economic contribution to the Canadian healthcare system of informal care at $25-26 billion dollars per year (Hollander, Liu, and Chappell 2009).

Canadian continuing care policy in all provinces involves some expectation of filial responsibility: that is, family members, particularly adult children, are expected to provide care as well as financial resources to their older relatives (Keefe 2011). However, because Baby Boomers had fewer children than previous generations, there will undoubtedly be fewer adult children available to provide care for them. Given current demographics, older adults living in the community with both a surviving spouse
and at least one surviving adult child receive about 17% of their assistance from formal sources. Among those without a surviving spouse or adult child, about 37% of assistance comes from formal sources (Keefe 2011). It is estimated that, by 2031, as many as 1 in 4 elderly women (who tend to outlive male spouses) will be without a surviving child (Keefe 2011). This trend will result in a substantial reduction in the provision of informal care.

In addition to demographic pressures, social changes also contribute to a changing capacity to provide unpaid care. The majority of unpaid care has historically been provided by women, but increasing labour force participation means that past assumptions about the amount of care that can be provided by female spouses and children may no longer hold (Keefe 2011). Also, the current trend of both men and women remaining in the workforce longer is projected to continue into the future (Carrière and Galarneau 2011), which may also affect caregiving capacity.

Family dynamics have also changed. Increased rates of divorce and the concurrent increase in blended families (families in which children are only genetically related to one parent) have changed expectations of filial responsibility (Guberman et al. 2012; Keefe 2011). Increasing outmigration in a number of Canadian regions will continue to lead to geographic separation between adult children and their aging parents (Keefe 2011). It has also been suggested that Boomers have different expectations of the care they should be expected to provide for their aging parents and that their adult children should have to provide for them. As a generation that has grown up with the welfare state and a robust social safety net, Boomers may have a greater expectation that public programs will be available as a component of the care they receive than previous
generations (Guberman et al. 2012; Blein et al. 2009). Taken together in the current policy environment, these demographic and social factors will undoubtedly increase the demand for formal care services, including LTC.

The third factor leading to increased demand for LTC services is the lack of available substitutes. In a policy environment where there is less societal capacity to provide informal, unpaid care, formal home care services are often inadequate or prohibitively expensive, and provincial governments are focused on discharging ALC clients from acute care beds as quickly as possible for cost-containment purposes, institutional care becomes the only viable alternative in many cases. This issue is of particular concern to older adults of lower socioeconomic status, who are more prone to chronic illness, more likely to be living in inaccessible homes with physical deficiencies, and whose informal carers are less able to leave the workforce in order to provide care (Golant 2008).

**Policy Problem**

Focusing continuing care policy on keeping seniors in their homes longer, as many provinces have done in recent years, is a commendable goal. Allowing seniors to “age in place” with enhanced home care and housing options has been a key priority for many Canadian provincial governments since the 1990s, for good reason. Survey data has shown that most older adults would prefer to live in the community for as long as they are able (Senate of Canada 2009; Bayer and Harper 2000), and residential care comes at a substantially higher cost to governments than home care or assisted living options. However, this goal has often ignored the reality that there is a certain percentage of the
older adult population (i.e. the very frail, those with advanced dementia) for whom this is not possible.

Given the proposed factors that are expected to drive increased demand for LTC as the demographic shift unfolds, provincial governments will need to examine how best to provide quality LTC to those who need it while also considering investment in other aspects of the continuing care continuum. This discussion will likely take place in an environment of fiscal restraint, and continuing care will compete with other pressing health system priorities that have in the past dominated the health policy discussion, such as primary care and acute care.

**Research Question**

This thesis aims to answer the following question:

Have changes in continuing care policy in response to demographic change and social and economic trends since the 1990s influenced: 1) LTC financing, including shifts in the public/private ratio of financing and among sectors, and 2) LTC quality, as measured by a standard set of quality of care indicators?

**Methodology**

This study involves a retrospective comparative case study of changes in continuing care policy in three provinces (British Columbia, Manitoba, and Ontario) since 1990. These provinces were chosen for analysis because comparable data on spending and LTC quality are available for each, and also because of the divergent policy paths they have taken in addressing the care needs of an aging population. A comparative public policy lens adapted from the work of Richard Rose (2005) is used to compare policy elements in each province. This analysis begins with a comprehensive literature
review that is based on government continuing care and LTC policy documents and vision statements, think-tank reports, positions taken by organized labour, as well as peer-reviewed literature. This review leans most heavily on government documents in order to better understand the stated intentions of policy reforms and the language used to describe them. The provincial experiences are compared, with specific attention paid to the stated goals of continuing care reforms, similarities, differences, and innovative practices from each jurisdiction. Comparisons are drawn with reference to the administration and organization of LTC services, the distribution of total spending from public and private sources, and whether the percentage of funding they receive as a percentage of total health spending and relative to the amount spent on acute care has changed over time. The spending data were obtained from the Canadian Institute for Health Information’s National Health Expenditure Database public microdata.

An evaluation of LTC quality in each province was conducted. Data for this comparison was obtained from the Canadian Institute for Health Information’s Continuing Care Reporting System’s publicly-available Quick Stats publication. Provincial comparisons are made on rates of adverse events, such as falls, worsening of a variety of health status indicators, including cognition, behavioural symptoms, continence, depression, and pain, and adherence to clinical best practices with regard to medication and physical restraint use.

With these three provincial case studies as the background, the Canadian continuing care policy cycle is explored in a more conceptual manner based on an adaption of the five part policy cycle framework proposed by Howlett, Ramesh, and Perl
Specific attention is paid to the first three segments of the policy cycle, including problem definition, agenda setting, and policy development.

Although access to LTC is an important theme of this research and is discussed throughout, no data could be found that describe access in a way that is reliable. Thus, access largely refers to the overall trend in the number of LTC beds in a given province. This way of defining access is limited as it does not address the change in need for LTC beds or any discrepancy between bed availability in urban versus rural settings.

With regard to the organization of the document, the current chapter has introduced the continuing care policy problem faced by Canadian provincial governments. Building on this foundation, Chapter 2 will provide a more in-depth overview of the historical and current continuing care policy context in Canada. Chapter 3 will examine the continuing care policy cycle in Canada, with specific focus on problem definition, agenda setting, and policy development. Chapter 4 will outline the provincial elder care policy changes in British Columbia, Manitoba, and Ontario since 1990, with a comparison of LTC, home care, and assisted living policy. The effects of these policy changes on LTC spending and quality will be discussed in Chapters 5 and 6. Chapter 5 will analyze and compare public spending on LTC in each province, with comparison to private, out-of-pocket spending, spending on home care, and growth rate compared to total health spending and the hospital sector. Chapter 6 will analyze and compare long-term care quality in each province, using 8 indicators from the Canadian Institute for Health Information’s Continuing Care Reporting System. Chapter 7 will summarize the lessons drawn from the provincial case studies and the challenges and
opportunities in the LTC sector generally, making specific recommendations for a sustainable, high quality LTC sector.
Chapter 2: LTC Policy Context in Canada

Historical Context

To truly understand the LTC policy landscape, one must first understand how the existing governance of LTC has evolved over time in the Canadian health system. Medicare was conceived of and implemented at a time in Canadian history when the medical model was greatly focused on curative treatment for the very ill or gravely injured, and the hospital was the centre of the system. Medicare’s insured services included services provided in hospital (introduced in the Hospital and Diagnostic Services Act of 1957) and physician services (introduced in the Medical Care Act of 1966). Extended health care services, which included nursing home intermediate care service, adult residential care service, home care service, and ambulatory health care service (Canada Health Act 1984), remained uninsured under Medicare (Canadian Healthcare Association 2009). These categories remained in place in the Canada Health Act of 1984, and indeed still form the basis for what is “in” and what is “out” of Medicare.

The introduction of the federal Established Programs Financing Act in 1977 replaced a previous 50/50 funding arrangement for insured health services between the federal government and the provinces with a block funding arrangement. The EPF also provided a small amount of directed funding for LTC and home care, which afforded provinces the necessary flexibility to gradually increase investment in extended health services such as LTC. While federal transfer payment regimes have changed over time, the current Canada Health Transfer and Canada Social Transfer function in much the same way as the EPF, in that provinces have flexibility to use the funds to invest in areas
outside of insured health services if they so choose (Canadian Healthcare Association 2009).

Historically, LTC in many Canadian provinces was provided by independent not-for-profit organizations including charities and religious organizations, a fact that remained unchanged by the introduction of Medicare. Provincial governments gradually entered this space, first as regulators and licensers and eventually as funders and, in most provinces after the introduction of regionalization, as operators of at least some LTC facilities. However, the focus on insured health services and relative neglect of extended health services like LTC has resulted in a patchwork of provincial programs, each with different funding formulas, operational standards, and legislative systems (Canadian Healthcare Association 2009). Some provinces, such as New Brunswick and Newfoundland and Labrador, still rely most heavily on the not-for-profit sector for LTC homes, while other provinces, most notably Ontario, have built bed capacity through the private, for-profit sector (Berta, Laporte, Zarnett, Valdemanis, and Anderson 2006).

Undeniably, the demands and expectations placed on a health system have changed since the introduction of Medicare in 1957. A movement towards deinstitutionalization for individuals with physical disabilities or mental illnesses, who had long been housed in segregated institutional care facilities unfolded in the 1960s and 1970s (Romanow and Marchildon 2003; Centre for Community Based Research n.d.). The 1974 release of A New Perspective On The Health of Canadians, a report by Marc Lalonde, Minister of Health and Welfare in the government of Pierre Elliott Trudeau, served as a watershed moment for our understanding and conceptualization of health, and consequently for Canadian health policy. The Lalonde Report is widely acknowledged as
the first declaration by a major industrialized nation that biomedical interventions were not the most important determinants of the health and wellbeing of populations (McKay 2001). These two shifts toward care provided in the community and the health of populations represented a substantial philosophical shift in Canadian health policy, the effects of which are still being realized today.

The late 1980s through the 1990s represented a tumultuous time in Canadian health policy. In response to rising health care costs, six Canadian provincial governments initiated task forces or arm’s length commissions to study and report on the effectiveness and efficiency of their health systems. All but one report recommended the devolution of authority to regional health authorities (RHAs). By the early 1990s, many provinces had begun the process of regionalization (Marchildon 2006). Regionalization occurred at a time when cuts to federal transfer payments to provinces were looming and debt reduction was a priority for provincial governments. Regionalization was, in many provincial cases, used as a vehicle for rationalization of health services at the same time as reforms were being rolled out (Marchildon 2006).

LTC has certainly been impacted by such shifts in the Canadian health policy environment. First, although the increased focus on public and population health, and in particular the social determinants of health, has been a vital paradigm shift, it has also added new services to the on-going competition for limited resources among extended health care services. Second, the unintended consequence of cultures of deinstitutionalization and care provided in the community has been the pitting of home care against care provided in a facility. Jansen (2011) argues that our current societal view of elder care sets up a dichotomy of “home as noble and facility as failure”. While
this dichotomy is likely consistent with older adults’ desires to remain at home longer, it is not reflective of the realities of the unmet care needs of a significant proportion of older Canadians.

Regionalization has also affected LTC policy as responsibility for LTC homes has been devolved to regional health authorities in most provinces. In theory, this allows for services to be better aligned to local needs and better integrated into the overall continuum of care. However, there are concerns that a regionalized system has further exacerbated the uneven distribution of LTC services between urban and rural areas (Canadian Healthcare Association 2009). There is also little evidence that regionalization has resulted in better care integration, particularly between hospital and physician services and services provided in the community. It can also be argued that the political and economic currents of decentralization and deregulation of the 1980s and 1990s contributed to an explosion in private, for-profit ownership of assisted living and LTC facilities.

Current Policy Context

Today, extended health services such as LTC continue to exist in something of a policy vacuum (Jansen 2011). Although the federal government funds LTC indirectly through transfer payments and directly through the administration of programs by the Department of Veterans Affairs, no national criteria, principles, or high level coverage standards exist (Jansen 2011; Canadian Healthcare Association 2009). As previously noted, provincial LTC programs exist as a patchwork, with substantial provincial differences in availability of services, public financing, eligibility criteria, out-of-pocket payment, and data collection and reporting standards (Jansen 2011).
While the general organization and administration of LTC services has remained mostly unchanged, recent years have seen a substantial change in the acuity and care needs of LTC residents. Some observers have noted that, in recent memory, some LTC residents had only 1-2 easily managed chronic conditions, and that ensuring adequate resident parking spaces was an issue of substantial concern facing LTC managers, concepts that are fundamentally incongruous with today’s resident population (Samuelsson 2011; Lieberman and Doupe 2014). Delaying entry to LTC means that residents most often enter with multiple chronic conditions and require a great deal of assistance with activities of daily living such as feeding, toileting, social interaction, and mobility (Samuelsson 2011). LTC residents on average have a shorter length of stay than in the past, because they are generally admitted closer to end of life.

Costs

Fees charged to residents of publicly-subsidized LTC are generally based on the cost of room and board and not the costs of care required. At least from an administrative standpoint, health care costs, such as the salaries of health professionals and limited medical supplies, are funded through the provincial ministry or department responsible for LTC. Residents are also most often expected to pay out-of-pocket for other expenses such as clothing, eyeglasses, hearing aids, dental services, transportation, over-the-counter medications, dietary supplements, and any required co-payments for prescription drugs. In many cases, personal hygiene and care items must be supplied or paid for by the resident. A guaranteed portion of the resident’s monthly income is usually set aside and held in trust by the facility to be used for these “extra” expenses, and low income, heavily subsidized residents are afforded a small monthly “comfort allowance” in most
provinces. Extra fees are sometimes assessed when private or semi-private rooms are requested (CIHI 2013b).

Maximum monthly rates for residents vary greatly across the country, ranging from a low of $1674 in Ontario to a high of $3390 in New Brunswick. There are also substantial variations in how resident ability to pay is assessed; some provinces use flat fee systems, others use income testing, and still others use combinations of income and asset testing (CIHI 2013b). The average monthly income for married elderly couples (before taxes, but after transfers such as Old Age Security) in 2011 was $5317 (Statistics Canada 2013), so the maximum fees represent a substantial economic burden for those who require placement in LTC.

There are also ideological differences in the descriptions of how rates are determined. Some provinces, such as Alberta, Ontario, Nova Scotia, and PEI, are careful to describe a clear delineation between the accommodation rate paid by residents, and the health care rate paid by the government. Other provinces, such as Newfoundland and Labrador, New Brunswick, and Saskatchewan, do not: instead, they focus on the total costs of running the facility, including wages paid to health professionals to determine the rate charged to residents. Stadnyk (2009) argues that this reflects an important ideological difference among provinces. Moreover, the idea that residents are expected to directly pay for necessary care that, if it were provided in an acute care setting, would be covered under Medicare’s insured services, is often incompatible with Canadians’ assumptions about user fees in the Canadian health care system. It is also important to note that these standards apply only to publicly funded LTC facilities. In completely private care
facilities (private, for-profit facilities that do not receive public subsidy), no such delineation exists, and there is no maximum rate that can be charged to residents.
<table>
<thead>
<tr>
<th>Province</th>
<th>Minimum Monthly Rate</th>
<th>Maximum Monthly Rate</th>
<th>How resident contribution is determined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>NL</td>
<td>No minimum</td>
<td>$2800</td>
<td>Based on income and assets</td>
</tr>
<tr>
<td>PE</td>
<td>No minimum</td>
<td>$2328</td>
<td>Based on income only</td>
</tr>
<tr>
<td>NS</td>
<td>No minimum</td>
<td>$3075</td>
<td>Based on income only</td>
</tr>
<tr>
<td>NB</td>
<td>No minimum</td>
<td>$3390</td>
<td>Based on income only</td>
</tr>
<tr>
<td>QC</td>
<td>$1098</td>
<td>$1766</td>
<td>Based on income and assets</td>
</tr>
<tr>
<td>ON</td>
<td>No minimum</td>
<td>$1674</td>
<td>Based on income only</td>
</tr>
<tr>
<td>MB</td>
<td>$975</td>
<td>$2280</td>
<td>Based on income only</td>
</tr>
<tr>
<td>SK</td>
<td>$1023</td>
<td>$1948</td>
<td>Based on income only</td>
</tr>
<tr>
<td>AB</td>
<td>No minimum</td>
<td>$1465</td>
<td>Based on income only</td>
</tr>
<tr>
<td>BC</td>
<td>$959</td>
<td>$3059</td>
<td>Based on income only</td>
</tr>
</tbody>
</table>

Table 2.1. Monthly rates for LTC in Canadian provinces and how they are determined

(Sources: CIHI 2013b; Sun Life 2013)

* In some provinces (e.g. Quebec), means-testing is only used for clients who apply for public subsidy.
Future Needs

As described in Chapter 1, demand for LTC is likely to rise substantially as the Baby Boom Generation moves through old age in the coming three decades. While lengths of stay in LTC have decreased, another consequence of delayed entry has been a considerable increase in total days of LTC use by those aged 85 and up. An analysis by the Manitoba Centre for Health Policy used two regression models to estimate future need for LTC beds in that province (Doupe et al. 2011). The first model represented a worst-case scenario: that current per capita rates of use were the lowest they could get until after the generational shift has taken its course. The second model assumed that reductions in per capita use that have occurred for all population groups in recent years would continue to some degree in the future. Under the first model, it was projected that there will be a 49% increase in the number of LTC beds used by 2030/31, and under the second model, there will be a 29.1% increase in the number of beds used over the same time period (Doupe et al. 2011). These estimates reinforce the fact that even if demand for LTC is reduced through improved health and strengthened community supports, the current supply of beds will not be sufficient to address the needs of a rapidly aging population.

Some have stressed that rising demand for LTC may be best dealt with by investments across the continuum of care, with specific focus on more cost-effective domains like assisted living, home care, and enhanced supports for informal carers (McGrail 2011). Indeed, the Manitoba Centre for Health Policy study notes that care settings like assisted living will need to adapt to accommodate clients with higher care needs, as governments are unlikely to increase supply of LTC beds to meet the coming
demand (Doupe et al. 2011). As will be discussed further in the next chapter, the three provincial case studies (ON, MB, BC) have made demand side investments in continuing care aimed, at least in part, at reducing institutionalization of older adults. Still, given the demographic and social changes described in Chapter 1, it is difficult to imagine how the continuing care system as it is currently structured will be able to respond without increasing LTC capacity.

Quality

LTC quality measurement is an issue of substantial debate in health and aging policy. Quality has generally been conceptualized as *quality of care* and measured on the basis of clinical indicators and outcomes. The clinical outcomes used as a proxy for quality of care have often been indicators of poor healthcare or unmet clinical guidelines/benchmarks (Samuelsson 2011). This focus on the “negative” aspects of care in combination with media reports about atypical cases of neglect, harm, and risk undoubtedly contributes to a negative public perception of LTC.

It has been argued that going beyond clinical indicators to measure *quality of life* in LTC may give a more robust picture of the resident experience. Samuelsson (2011) states that “(r)esidents rarely equate quality of life with the absence of unmet regulatory standards.” Residents are more likely to define their quality of life using non-clinical factors such as being treated with respect, being part of an inclusive community, and their perceptions of staff competency (Samuelsson 2011).

Regardless of how we choose to define quality, however, reliable and comparable quality data are difficult to obtain. The Resident Assessment Instrument- Minimum Data Set (RAI-MDS), a standardized, electronic assessment tool used upon admission and at
specified time points thereafter, is gradually becoming the standard in all Canadian LTC facilities. However, even among provinces that require use of the RAI-MDS, a number do not provide these data to CIHI for aggregation within their Continuing Care Reporting System. This makes it difficult for LTC managers and provincial and regional health authority leaders to compare their performance with that of other jurisdictions (CIHI 2013c).

A 2013 CIHI report proposes a suite of eight quality indicators derived from the RAI-MDS that can be used as a standardized measure of LTC quality. While these indicators necessarily relate to clinical outcomes, a dimension on quality of life is included which captures information on the proportion of clients with worsened depression, pain, and behavioural symptoms. The other dimensions include physical function (maintained or improved ability to transfer, walk, and wheel; worsened bladder incontinence) and safety (fall in previous 30 days; use of an antipsychotic drug without diagnosis of psychosis; new stage 2-4 pressure ulcer) (CIHI 2013c). These indicators and their importance to care quality will be explored in greater detail in Chapter 6.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsened depression</td>
<td>Quality of Life</td>
<td>Mood worsened during previous 90 days according to Depression Rating Scale (part of RAI-MDS standard assessment).</td>
</tr>
<tr>
<td>Worsened pain</td>
<td>Quality of Life</td>
<td>Pain worsened during previous 90 days, as measured by interRAI Pain Scale (part of RAI-MDS standard assessment).</td>
</tr>
<tr>
<td>Worsened behavioural symptoms</td>
<td>Quality of Life</td>
<td>Increased number of challenging behaviours (such as wandering, verbal or physical abuse, and socially inappropriate behaviour) reported over previous 90 days.</td>
</tr>
<tr>
<td>Maintain or improve ability to transfer</td>
<td>Physical Function</td>
<td>Maintain or improve ability to transfer in and out of a bed or chair and ability to walk or wheel around the LTC facility over previous 90 days.</td>
</tr>
<tr>
<td>Worsened bladder incontinence</td>
<td>Physical Function</td>
<td>Bladder incontinence worsened in over previous 90 days.</td>
</tr>
<tr>
<td>Fall in previous 30 days</td>
<td>Safety</td>
<td>Reported fall in previous 30 days.</td>
</tr>
<tr>
<td>Inappropriate antipsychotic drug use</td>
<td>Safety</td>
<td>Received an antipsychotic medication without a corresponding indicated diagnosis (schizophrenia, Huntington’s syndrome, or hallucinations) in previous 90 days.</td>
</tr>
<tr>
<td>New stage 2-4 pressure ulcer</td>
<td>Safety</td>
<td>Developed a new stage 2-4 pressure ulcer in previous 90 days.</td>
</tr>
</tbody>
</table>

Table 2.2. LTC Quality Indicators. Source: CIHI 2013c.
Conclusions

The range of options available to policymakers in attacking the policy problem of access to high quality LTC is very much determined by the historical funding and regulatory arrangements discussed in this chapter. In one sense, the fact that LTC falls outside of Medicare’s insured services is a limitation, as it is not guaranteed a stable source of federal funding such as the Canada Health Transfer. While federal funds from the Canada Social Transfer may be directed toward LTC (or continuing care more generally), there are many disparate competing priorities in the social services sector that also require stable funding and attention.

In another sense, the fact that LTC falls outside of Medicare does allow for a greater range of options to be considered by provincial policymakers. As no federal regulations or standards are imposed on LTC, each province has been free to develop its own, and is able experiment with both financing and delivery of these services. One example is the wide range of user fees for publicly subsidized LTC across the country shown in Table 2.1, ranging from most expensive (at maximum) in New Brunswick to least expensive in Alberta. Provinces can also choose to invest in the continuing care sector in a variety of ways with no limits on the involvement of the private sector.
Chapter 3: LTC Policy Options

Any exploration of future directions in LTC policy must begin with a discussion of public policies and how they are developed. Jenkins (as quoted in Howlett, Ramesh and Perl 2009) defines public policy as “a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them” (6). The public policy cycle, then, is the “regular business of government” (Marchildon 2007, 113), a “set of interrelated stages through which policy issues and deliberations flow in a more or less sequential fashion from ‘inputs’ (problems) to ‘outputs’ (policies)” (Howlett, Ramesh, and Perl 2009, 10). If the public policy cycle functions effectively, policies are developed in a way that is incremental and systematic (Marchildon 2007).

Howlett, Ramesh, and Perl (2009) propose a five-stage public policy cycle, shown in Figure 6.1. This chapter will focus on the first three stages of this cycle: agenda-setting, policy formulation, and decision-making, as LTC is currently on the policy agenda of provincial governments, and a variety of policy options are available for consideration and study by decision-makers. It should be noted that the policy options to be discussed in this chapter are not mutually exclusive, and that enacting one of these policies does not preclude enacting any other. The purpose of this chapter is to describe the range of options currently available to government rather than to recommend the adoption of one specific policy. The relative merits of these policy options will be discussed in more detail in Chapter 7.
Figure 3.1. The public policy cycle (Source: Howlett, Ramesh, and Perl 2009).
Agenda Setting

Agenda setting is the first stage of the policy cycle, at which a policy problem is recognized and singled out for a government’s consideration (Howlett, Ramesh, and Perl 2009). Kingdon’s Multiple Streams theory (1984) provides a useful lens through which to examine agenda setting in Canadian LTC policy. This theory posits that there are three streams that influence the attention that is paid to a given policy problem by governments at the agenda setting stage.

The first stream is the problem stream, which deals with larger policy problems which may require a policy response, and how these problems are defined by the various actors in the policy process. The extent to which these problems are prioritized by decision-makers determines their rise to the top of the policy agenda. The second stream is the policy stream, which is the process in which policy alternatives are generated and put forth for debate and consideration. Policy alternatives are most often considered on the basis of cost, technical and political feasibility, and perceived popularity with the general public (Sitaker 2010). The third stream is the political stream, which encompasses the political, structural, and legal factors that influence both agendas and the political feasibility of proposed alternatives. The political stream includes political ideology or priorities of the government of the day, the general political climate or mood, the election cycle or change of elected representatives, and the visibility of influence groups who may have a vested interest in a given policy problem or response. It also includes jurisdictional concerns and legal frameworks that influence what alternatives will be considered viable.
These three streams operate independently of one another, and often “have lives of their own” (Sitaker 2010). When all three streams converge (that is, when there is a pressing problem and policy alternatives that are technically and politically viable), a policy window is opened in which a policy response can be generated and implemented. Crucial to the convergence of the streams is the presence of policy entrepreneurs who find problems to which to attach their preferred policy response. Policy entrepreneurs potentially include elected representatives, civil servants, journalists, academics, think tanks, and organized labour or other interest groups. Policy entrepreneurs advocate for a specific definition of the problem and favour certain policy responses over others. Policy entrepreneurs advocate by highlighting indicators of the problem, sometimes using empirical evidence and sometimes with anecdotal accounts that highlight the effect of the problem or proposed policy response on individual citizens. This policy advocacy takes a variety of different forms, including giving testimony before government panels or commissions, holding hearings, garnering press coverage, writing reports, writing blogs or op-eds, and holding public meetings or consultations.

Multiple Streams in Canadian LTC Policy

Problem Stream

Three macro-level policy problems influence the LTC policy environment in Canada. The first is population aging, which is discussed in greater detail in Chapter 1. A variety of concerns have been raised with regard to the effects of population aging on the health system as it is currently structured. The Baby Boom generation has already begun to reach the age of 65 and although there is disagreement about the stresses this demographic shift will place on the Canadian health system, the care needs of this
unprecedented cohort of older adults represents a problem that requires an immediate solution (Simpson 2014; Health Council of Canada 2012).

The second policy problem influencing LTC policy is the growing government focus on health system pressure points, in particular ALC and the potential “bed blocking” effects it is having in the acute care sector. ALC is a significant area of focus for governments due to the added costs and inefficiencies it creates, as discussed in Chapters 1 and 2. The continuing care sector as a whole and LTC in particular can play a role in solving this problem.

The third policy problem influencing LTC policy is the desire of governments to “bend the cost curve” in health care. While LTC does not garner the same amount of attention from policy makers in this debate as hospital and physician services, its role is often discussed. LTC’s position in the health care cost debate is unique: it is substantially less expensive for governments to provide than hospital care in the case of ALC, but substantially more expensive than other non-institutional options such as home care and assisted living.

These macro-level problems (population aging, ALC, and reducing costs) are broadly agreed upon as significant health system challenges Canadian policymakers must grapple with. However, the way in which these problems are framed at a more granular level, can influence the likelihood of an issue being added to and rising up a government’s agenda and, once on the agenda, what policy responses are considered. This aspect of the policy process, referred to as problem definition, reflects the ideas, assumptions, and worldviews that policy entrepreneurs bring to a given problem (Weiss
1989). In some cases, problem definition is not definitively settled even as the policy process unfolds (Weiss 1989).

Certain problem definitions undoubtedly shape the potential policy responses. For example, if ALC were regarded primarily as a problem of inappropriate use of the health system rather than a lack of available continuing care options for older adults, policy responses may centre on creating economic disincentives to accessing acute care, such as user fees. While this response would likely help curb inappropriate use of acute care, it would not deal with the underlying capacity issues in continuing care, and would indeed create an undue barrier to access for those of lower socioeconomic status (Canadian Foundation for Healthcare Improvement 2012).

Policies Stream

A variety of policy alternatives for LTC have been discussed, proposed and implemented across Canada. They include: public investment in LTC beds, public investment in alternatives to LTC, LTC funding reform, LTC insurance, and tax credits and enhanced personal saving options. It should be noted that the adoption of these alternatives is not necessarily an either/or proposition, as multiple alternatives can be adopted concurrently, as has happened in some jurisdictions.

Policy Option 1: Public Investment in LTC Beds

In recognition of the fact that a greater number of LTC beds will be required in the future, one policy option is to increase the number of beds available for publicly subsidized (and mainly high-needs) clients. There are a variety of ways in which this can be accomplished. Newfoundland and Labrador, for example, has invested in six new LTC facilities developed and funded entirely by the provincial government, including a 460
bed facility in St. John’s (Newfoundland and Labrador 2014). The Province of Manitoba has announced funding for new publicly funded LTC facilities, and has also partnered with community not-for-profit groups to support facilities built without direct provincial investment (Manitoba 2013).

Public-private partnerships are being utilized in Saskatchewan, where a new 225 bed facility (to replace an existing 198 bed facility) in Swift Current is to be built through a partnership between the Province of Saskatchewan, Cypress Health Region, and the private sector (SaskBuilds 2014). New Brunswick has also entered into a public-private partnership with Shannex Inc. to build 216 new LTC beds across 3 facilities, which are the first private, for-profit facilities in operation in the province (New Brunswick 2010). The Province of Alberta has also looked to the private sector to build LTC capacity, offering public land to private for-profit or not-for-profit corporations to support the construction of new facilities (Henton 2014).

Policy Option 2: Public Investment in Alternatives to LTC

Another policy option is to invest in other continuing care services that can provide an alternative to LTC or delay entry to LTC facilities. Services such as home care and assisted living, as described earlier in this thesis, are lower cost options for provincial governments than LTC, and their availability on the continuum of care can help to prevent premature LTC admission (Golant 2002; Canadian Healthcare Association 2009). For many older adults, these options are preferable to LTC as they are perceived to allow for the maintenance of independence and autonomy.

Home care is subsidized to some degree in all provinces, although the hours and basket of services available under public programs varies. For example, in Ontario all
professional home services (such as nursing, occupational therapy, and physiotherapy) coordinated through CCACs are provided free of charge, but home support services such as homemaking are not under the purview of the CCACs, thus not subsidized (Jones 2007). In Manitoba, home of Canada’s oldest comprehensive public home care program, home support services such as homemaking (including meal preparation, cleaning, and laundry) are covered, while respite services outside of the home are available for a fee (Manitoba n.d.).

Public investments in home care could happen on the supply side, by hiring or contracting out for more providers, including nurses, care aids, and allied health professionals who are on the front-line of care. This would in theory allow for more clients to be seen within the public home care system, and could potentially allow for the higher service intensity required to support older adults at risk of LTC admission at home. Demand-side investments could also be used by increasing public subsidy to those deemed eligible for home care, allowing them more flexibility to purchase privately delivered home care services.

Investment in assisted living as an alternative to LTC is another version of this policy option. While substitution is occurring in most provinces (McGrail et al. 2012), there is little quantitative data on the scope and scale of the expansion of assisted living and to what extent it is occurring as a publicly induced alternative to government investment in LTC. As previously noted, British Columbia, as the first province to regulate and subsidize public and private assisted living residences, provides a useful case study in this regard. British Columbia is also the first province to integrate these facilities into the formal care continuum for older adults (McGrail et al. 2012; Jones
2007). In Ontario, the Ministry of Health and Long-Term Care funds 185 assisted living programs, although concerns have been raised that these are mainly concentrated in urban areas, and access varies across the province (Jones 2007). Since 2006, Manitoba has also invested in a publicly financed assisted living program, although this program is quite small in scale, and, like in Ontario, not available in all communities (McGrail et al. 2012).

Investments in this sector from provincial health ministries have (at least, so far) focused primarily on the demand side. Because there is often considerable overlap between the mandates of assisted living and other social housing projects, responsibility for capital costs of these facilities often falls to provincial and municipal housing corporations, sometimes in partnership with the private sector (Jones 2007). Private, for-profit options also exist throughout the country. Thus, the focus, at least from the perspective of a health ministry, is to provide subsidy for clients.

Policy Option 3: LTC Funding Reform

Regardless of the mix of continuing care services, governments still face ongoing pressures to allocate limited financial resources for LTC in a more efficient way. Currently in most parts of the country, payments to LTC facilities from RHAs are made using global budgeting. Under this system, the operating costs used to calculate the budget for facilities are determined by a per diem system that takes into account only the number of residents and historical funding levels, not the complexity of care required by those residents. This creates a problem of adverse selection (or, as it is colloquially referred to in this context, cream-skimming), as the per diem system makes it favourable
for facilities to seek out residents who require lower levels of care and thus incur lower costs (CIHI 2013e; Sutherland, Repin, & Crump 2013).

Activity-based funding (ABF) has been proposed as a means of allocating limited dollars for acute and LTC institutional care more efficiently. Under ABF, funding for facilities is calculated on the basis of the complexity of clients and the kinds of specialized care provided in the facility, often using algorithms found in existing standard assessments, like the interRAI tools. While methods and formulas vary, Alberta (using a system referred to as Patient/Care Based Funding) has recently introduced ABF as a means of financing all LTC facilities under the purview of Alberta Health Services (Sutherland, Repin, & Crump 2013). Ontario’s ABF funding model, referred to as the Health-Based Allocation Model, is currently applied to funding for hospitals and home care, and will be expanded to include LTC in the near future.

The main policy objective of ABF is to give policymakers price control over each unit of activity in a care setting, allowing for incremental adjustments over time. This theoretically should result in a more efficient and equitable distribution of funds and efficiency gains (CIHI 2013). However, critics contend that ABF formulas rely too heavily on historical funding levels, lead to system gaming by health administrators, and ignore underlying system level issues such as equity (Rachlis 2008; Cohen, McGregor, Ivanova, and Kincaid 2012).

Policy Option 4: Long-Term Care Insurance

Long-term care insurance is a relatively new concept in Canada, but one that has garnered significant policy attention in recent years. It has been argued that continuing care services will continue to be marginalized in the Canadian health policy environment
without the establishment of a specific and stable funding stream for these services (Hébert 2011). The use of long-term care insurance (which refers to an insurance scheme that covers a given set of continuing care services, including LTC) may create such a stable source of funding and eliminate some of the cost-barriers faced by older adults. There are two potential vehicles for long-term care insurance: private insurers, or a public-insurance program.

Private insurers have already begun to enter this market, although there is no available information on how many Canadians have purchased long-term care insurance to date. Sun Life, for example, advertises policies which range from covering care provided in LTC facilities only to policies that cover home or facility-based nursing care, rehabilitation or therapy, personal care, homemaking services, and personal support workers (Sun Life 2014).

While governments could act to incentivize the purchase of private long-term care insurance, there are a variety of problems that may limit the effectiveness of private insurance schemes. For one, an optional private insurance scheme is unlikely to have adequate risk pooling, as younger people who are at much lower risk of requiring continuing care services may be unwilling to purchase such a product until later in life. This could lead to long-term care insurance being unaffordable for middle-class and lower income Canadians. As discussed earlier in this document, there is also an expectation gap among Canadians, at least some of whom may be unaware that continuing care falls outside of the Medicare basket of services, and this lack of understanding may contribute to lower uptake of private insurance relative to other countries (Grignon and Bernier 2012; Hébert 2011).
Grignon and Bernier (2012) also argue that, because the risk of requiring intensive continuing care is not equally distributed, a private option could result in some who do not require care saving too much, and others who require care saving too little, as costs may be expected to exceed the premiums paid out. There is also concern that the availability of last resort options within the public system (i.e. being admitted to an acute care facility) influences the decision of whether or not to purchase long-term care insurance (known to economists as free-riding behaviour), as individuals know that, with or without insurance, they will have the option of receiving some level of care (Grignon and Bernier 2012).

A number of experts have argued that a public long-term care insurance scheme would be a preferable policy option for paying for continuing care in the future (Grignon and Bernier 2012; Hébert 2011). Hébert (2011) argues that establishing a stable funding pool for continuing care services through the use of a public insurance program would take continuing care services out of competition for funding with other health services. However, a variety of questions must be answered about such a scheme. Would it be paid for through taxation or through premiums? What services would be covered? Would payouts be made through in-kind payments to providers or directly to beneficiaries to allow them to choose and purchase the services they want?

Quebec provides one example of such a public insurance scheme where a bill proposing Assurance-Autonomie (Autonomy Insurance) died on the order paper when the 2014 provincial election was called. Former health minister Réjean Hébert, a geriatric physician and researcher with expertise in the organization of care for frail older adults before entering political life, was instrumental in developing this proposed policy. A
2013 white paper on the policy describes Autonomy Insurance as a plan that would eventually cover all Québécois aged 18 and up who require long-term aid, support or care. The main expected beneficiaries were seniors experiencing functional or cognitive losses, individuals with physical or intellectual disabilities, and individuals experiencing functional impairment as a result of chronic, debilitating diseases (Quebec 2013).

The white paper describes a relatively limited number of insured services delivered in the home, including professional care (e.g. nursing, nutrition, rehabilitation, and psychosocial care), personal care (e.g. bathing, dressing, feeding), and home support (e.g. housekeeping, meal preparation). With regard to funding, the white paper suggests a scheme that is funded primarily through existing sources and user fees, but notes that additional revenues would be needed in the future, particularly if the basket of services were to be expanded (to include accommodation fees for assisted living or LTC, for example) (Quebec 2012). A 2011 academic paper by Hébert, submitted and published before he was elected to public office, provides more insight on what an expanded, premium-based plan would look like. In it, he proposes that pay outs from the public insurer could take place in two forms: in-kind payments to public providers and an allowance provided to beneficiaries to purchase services from private sources at their own discretion. The allowance could also potentially be used to pay for assistive devices, home modifications for safety and accessibility, and social benefits for informal caregivers. Hébert (2011) also notes that all Canadian provinces already possess the capacity to assess clients for such a program through standardized assessments already in use such as the RAI.

*Policy Option 5: Enhance Private Savings through Tax Credits and other Instruments*
Given the proliferation of the private sector in continuing care and the rising out-of-pocket spending on these services, another proposed policy option is to enhance private savings to pay for care later in life. This option was given specific attention in a 2012 research report catalogued in the Library of Parliament. Encouraging and incentivizing private savings is recognized as the predominant role for the federal government in continuing care funding (Cool 2012). Indeed, the federal government has made small strides in this area with the 2012 introduction of the Family Caregiver Amount, an annual tax credit of $2040 made available to family members who provide care to a loved one (Canada Revenue Agency 2014).

While there is certainly a role for the federal government to play in enhancing private savings through policy instruments like tax credits, provincial taxation regimes must also be heavily involved. To ensure adequate savings, individuals would need to start saving during the working years. It is estimated that, to pay for five years in a nursing home, individuals would need to save $300,000 during working years, and $150,000 per partner for couples (Grignon and Bernier 2012).

While a myriad of existing federal and provincial tax credits can be said to help enhance personal savings, two particular policy instruments have been proposed as a means of enhancing savings for continuing care. The first is medical savings accounts, which have been used elsewhere in the world, though predominantly to pay for acute care services. Medical savings accounts could be modelled after the existing registered retirement savings plans (RRSPs), in that the entire amount would be tax-exempt provided that the money saved was used to purchase continuing care services. Medical savings accounts could also resemble tax-free savings accounts (TFSAs), in that
contributions are made using taxable income while the interest or income generated by the savings is non-taxable (Grignon and Bernier 2012).

The second proposed policy instrument is the reverse mortgage, also referred to as an equity release in the U.K. The reverse mortgage allows a homeowner to essentially sell their home back at a discounted price to a bank or government agency but remain living in them as long as they are able, receiving regular payments from the buyer as a source of income (Grignon and Bernier 2012). Governments could play a regulatory role in this market, or they could also fill the role of a risk-neutral buyer, creating a government agency that pays up front for the continuing care costs borne by the individual and recoups these costs by selling the home after beneficiary dies (Grignon and Bernier 2012).

Both medical savings accounts and reverse mortgages depend quite heavily on the financial status of individuals. Medical savings accounts require individuals to have an income that allows for a substantial amount to be “put away” on a monthly or annual basis in order to pay for potentially catastrophic care needs. Reverse mortgages are only an option for homeowners, and two groups of homeowners stand to benefit the most from this option: those with the highest valued homes, and those who live long enough to “take out” the full equity of their home. It may be argued, however, that allowing those of higher socioeconomic status to avail themselves of these options has the potential to reduce pressures on the needs-based policy approach to continuing care in Canada.

In assessing the private savings policy option, Grignon and Bernier (2012) argue that even in other nations where private savings is used as a primary option for continuing care, such as the United States and Singapore, governments have still felt the
need to step in to fill the gaps. In the United States, for example, catastrophic continuing care expenses are covered under Medicare and Medicaid. In Singapore, a voluntary government insurance scheme exists (Grignon and Bernier 2012). Given that risk is not equally shared across the population, relying heavily on private savings can lead to some individuals who will require no care or little care saving too much, and others, who will require long term, highly intensive care saving too little.

**Political Stream**

The political stream, as previously noted, describes the political climate that determines the issues that get on the agenda and the policy alternatives that are politically viable. This includes the political ideologies of the governing party, political priorities, the visibility or saliency of the issue, as well as overarching jurisdictional or legal constraints.

In terms of agenda-setting, it is safe to say that the three main problems identified in the problem stream (population aging, health system pressure points, and “bending the cost curve”) are high on the political agenda across Canada at this point in time. The three provinces reviewed in this study have paid particular policy attention to these issues. However, the way that these issues are framed and the proposed policy alternatives under consideration are constrained by four overarching and interconnected political issues. These issues are: 1) the Canada Health Act and the divide between insured and extended health services; 2) “aging in place” philosophy; 3) market-based solutions; 4) constraint of health spending ("bending the cost curve").

1. *Canada Health Act and the “tyranny of the acute”*
As discussed in Chapters 1 and 2 of this document, the policy legacy of Medicare has created a public healthcare system that is heavily focused on hospital and physician services. This legislative framework has necessarily shaped the mostly non-existent federal role in the continuing care sector. Tommy Douglas, the father of Saskatchewan’s provincial hospital insurance, the precursor of Medicare in Saskatchewan and at the federal level, discussed the need to extend federal cost-sharing for extended health services as a New Democratic Party (NDP) Member of Parliament in 1976.

“The provinces have been trying to persuade the federal government to join with them in instituting cost-shared programs for such services. A lot could be done in this country by the establishment of more nursing homes, the provision of home-care treatment, meals on wheels, more extended care units in hospitals…Those of us who through the years have talked about a new delivery system have been stressing the need for altering the focus on health care in this country. In the past we thought of the practice of medicine in terms of curative medicine and public health care, but many countries in the world now have switched their emphasis to preventative health programs…It is now eight years since we took the first step of establishing Medicare in this country. It was a forward step…However, we have taken few steps since to begin to change the health delivery system to any serious extent, and we are paying the price because the whole delivery system of merely curative medicine is expensive and will become increasingly expensive…What have we done about nursing homes? Some steps have been taken but they have been really meager.” (Douglas 1976, Hansard)

Two initiatives to directly fund continuing care services have come from the federal level. The EPF, including some directed funding LTC and home care, was introduced by the Trudeau government in 1977, a year after Tommy Douglas’ statement on the floor of the House of Commons. A similar directed funding initiative was undertaken as part of the 2003 Health Accord. On the basis of recommendations from the Romanow Commission, a one-time, directed transfer was undertaken to supplement first-dollar provincial financing of home care in three priority areas: post-acute care, mental health care, and end-of-life care (Canada 2006).
Given that continuing care services fall outside Medicare, directed transfers are one of the only policy tools available to the federal government to effect change in this sector. Although this is an area of provincial responsibility, provincial governments are still limited by the legislative constraints of the Canada Health Act, namely the distinction between insured and extended health services. Maclean and Greenwood-Klein (2002) argue that the presence of the Canada Health Act has helped to structure the debate about public healthcare among the public and politicians as primarily about acute care, while extended services like LTC have been stealthily privatized with little public discussion.

LTC and other continuing care services may also be marginalized in the political discussion for more practical reasons, however. Although federal governments have rarely enforced Canada Health Act principles, the Act does lay out a common basket of hospital and physician services, accessible without user fees at the point of care. These services must be provided by provincial governments, and evidence suggests that both the cost and utilization of these services is rising (CIHI 2013a). No such high level standards exist for continuing care services; thus, in an environment of limited resources, continuing care becomes easier to ignore.

Public expectations also come into play. Although there is an expectation gap within the Canadian public with regard to what the public healthcare system will provide for them as they age, there is far more precedence for, and acceptance of, both private sector delivery and user pay within the continuing care sector. Inherent to this acceptance is the assumption (right or wrong) that older adults, who have had a lifetime of earning
potential and are eligible for Canadian Pension Plan and Old Age Security payments, have the ability to contribute financially to their own care.

2. “Aging in Place” Philosophy

Aging in place, defined by the Forum of Federal/Provincial/Territorial Ministers Responsible for Seniors in 2012 as the “having the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able”, is a concept that has been prominent in social gerontology for nearly 30 years (Gutman and Blackie 1986). However, the language and philosophy of aging in place has been adopted in recent years by a number of provincial governments in their aging population strategies. In and of itself, promoting aging in place is an admirable policy goal, as it responds to the stated wishes of many older adults to remain in their own homes for as long as they are able (Health Council of Canada 2012). Organizing our health, social, and community services with the desires of older adults in mind is a pragmatic decision. However, such planning must also recognize that there are a number of vulnerable older adults for whom “aging in place” is not realistic or feasible.

The Governments of Ontario and Manitoba have made aging in place a key component of their elder care policy planning. To the credit of decision makers in both provinces, their aging in place (called “Aging at Home” in Ontario) strategies have focused on enhancing community living options and in-home supports for older adults while maintaining a robust continuum of care that includes LTC (Manitoba Health n.d.; Ontario 2010). However, there seems to be a clear ideological bias toward lower levels of care in this planning. A 2010 press release from Ontario’s Ministry of Health and
Long-Term Care, for example, touts that their Aging at Home strategy aims to “(avoid) the unnecessary loss of independence due to premature admission to higher care long-term care homes or hospitals.” This reinforces Jansen’s (2011) concept of “home as noble, facility as failure.” It is also unclear what constitutes “premature admission.” Given that the evidence discussed in Chapter 1 that shows a clear trend toward Canadian older adults being admitted to LTC later in life and with higher care needs, the extent to which premature LTC admission remains a problem is certainly debatable.

In a review of the peer-reviewed evidence, Dillaway and Byrnes (2009) argue that discourse around “successful aging”, which is often conceptualized as the absence of age-related disease and the maintenance of physical, cognitive, and social functioning, has shaped the aging policy discussion. An unintended consequence of this focus on maintaining health and independence has been that it privileges the experiences of relatively healthy, independent seniors over those who experience illness and functional loss (Dillaway and Byrnes 2009). The promotion of aging in place adds more criteria that are required to age “successfully”: having the social and financial resources to be able to remain in one’s own home.

Governments have little to lose by adopting the language of aging in place. The philosophy promotes programs that cost less to provide using language that appeals to older adults, who, by virtue of demographics and of voter turnout, hold a great deal of political power. While there is no evidence to suggest that the adoption of aging in place philosophy is fundamentally changing the mix of health services provided to older adults, it is certainly informing the political discussion. The policy dilemma, then, is one of Maslow’s hammer (1966): when the only tool you have is a hammer, everything starts to
look like a nail. The widespread acceptance of aging in place philosophy leads researchers and policymakers to believe that home care is the solution to all of the ills of the continuing care system. The consequences of frail older adults languishing at home longer and entering an already overburdened LTC system with higher care needs and closer to end-of-life are then pushed aside as secondary concerns.

3. Market-based solutions

In discussing what he termed “marketlike mechanisms”, Evans (1997) describes a continuum of private sector involvement in healthcare, with civil service organizations on one end and entirely private, for-profit entities at the other. Evans argues that in most countries, the vast majority of organizations that provide health care services do not fit cleanly into either category. This is certainly true of LTC and the continuing care sector as a whole, where private involvement by both the not-for-profit and for-profit sectors has been the reality for as long as the sector itself has existed.

Deber (2003) describes the “first law of cost containment”: that the simplest way to contain costs is to pass them on to someone else. For insured hospital and physician services, the discussion of who to pass costs on to is relatively simple, as provinces and the federal government debate the proper level of cost-sharing for these programs (Deber 2003). In the continuing care sector, however, it is possible to pass costs on to both the private sector, through partnerships to offset capital costs, and the users, through user fees.

Given the precedence for private involvement and the acceptance of user fees in the continuing care sector as well as the opportunity to shift costs, it is perhaps obvious that governments would favour private solutions and managed competition in this sector.
It can also be argued that this is merely part of a larger shift toward neoliberalism in Canadian policymaking, particularly in health policy (Bryant 2009, 19). However, regardless of underlying causes and major shifts in ideological direction, private sector involvement in continuing care is growing. One piece of quantitative evidence for this shift, shown in Chapter 4 (Figure 4.4), is the growing per capita private expenditure on LTC in all 3 provinces of interest since 2000. In a 2009 report, the Canadian Union of Public Employees (CUPE) also detailed the growth of the private, for-profit LTC sector. Qualitative examples of this phenomenon in continuing care abound, including a number that will be addressed in this document: British Columbia’s use of a request for proposal (RFP) process in tendering contracts for the construction of new LTC homes, Ontario’s use of Continuing Care Access Centres (CCACs) as a purchaser of private home care services in order to enhance competition, and the various public-private partnerships provinces have experimented with in constructing new LTC facilities. Putting aside the debate about whether or not this increased reliance on “marketlike mechanisms” is positive or not, it is clear that policy alternatives that could potentially shift costs from the public purse to the private sector or to users are favoured in today’s policy environment.

4. Constraint of health spending (“Bending the cost curve”)

Perhaps the key political consideration in all health policy is the need to constrain health spending and improve the value for money proposition. This comes amid warnings that the Canadian health system as a whole is in crisis as a result of spending growth occurring at a rate that is unsustainable. Experts, policymakers, and think-tanks, particularly those to the right of the political ideological centre, warn that health spending will eventually crowd out other government spending priorities, such as education and
infrastructure (Lewis and Sullivan 2013). Despite empirical evidence showing that overall growth in health spending has slowed in recent years (CIHI 2013a) and that crowding out has not taken place (Landon, McMillan, Muralidhuran, and Parsons 2006), the language of crisis is still prevalent in the discourse around healthcare and health policy.

Lewis and Sullivan (2013) point out that one key to bending the cost curve is bending the needs curve. Certainly, a robust continuing care sector can play a role in bending the needs curve by allowing older adults to be discharged more quickly from more expensive acute care settings, and potentially managing care in a way that prevents emergency department visits and acute care admissions. However, the language of crisis and the desire to constrain health spending can preclude governments from greatly expanding spending in a given sector.

**Policy Formulation**

The prevalent policy problems and wide array of well-developed policy options under consideration have created a *policy window* whereby LTC reform can at least have a privileged position on the agendas of governments in Canada. However, the degree to which the options from the policy stream are compatible with the political priorities from the politics stream determines their political viability.

The second stage of the policy cycle, known as policy formulation, deals with the identification, assessment, and discussion of options for dealing with a given policy problem (Howlett, Ramesh, and Perl 2009, 110-111). This stage has been theorized to consist of four phases: *appraisal, dialogue, formulation, and consolidation*. During the appraisal phase, relevant data and evidence about the policy problem and potential
solutions are identified and compiled. Sources of data may include research reports, expert advice, or public consultation (Howlett, Ramesh, and Perl 2009, 111). During the dialogue phase, governments consult with different policy actors. These consultations can take the form of open public forums or townhalls, or can be focused meetings with business leaders, labour organizations, experts, or other stakeholders (Howlett, Ramesh, and Perl 2009, 111). At the formulation stage, public officials weigh the evidence and stakeholder opinion and draft a policy proposal, often in the form of a white paper, a framework or draft legislation (Howlett, Ramesh, and Perl 2009, 111). When the consolidation phase is reached, policy actors provide feedback on the policy proposal. Some actors who initially advocated for other policy responses may come “on board” with the proposal at this point with the hope of influencing the policy process from within, while other dissenters may continue to advocate for a different response from the outside (Howlett, Ramesh, and Perl 2009, 112).

At the policy formulation stage, policy options are considered not only on the basis of evidence of best practice but also on the basis of their technical and political feasibility in the specific jurisdiction (Howlett, Ramesh and Perl 2009, 135). While the policy options outlined earlier in this chapter have been weighed and, in some cases, implemented in Canada and abroad, political factors will affect the likelihood of their adoption. For example, governments wishing to build LTC capacity through the private sector would likely hear about organized labour’s opposition to private sector expansion (CUPE 2009) during the dialogue phase, and face opposition from these groups at the consolidation phase. The decision whether or not to proceed with this option, then, would be influenced by the perceived political price organized labour could extract from the
government of the day. For example, governments may not wish to alienate public sector unions on the eve of contract negotiations. Similarly, expanding public LTC may not be a politically or technically viable option in an environment of austerity and cost containment.

Decision-making

The third stage of the policy cycle is decision-making, at which point an official course of action is decided upon, laying the ground work for the policy to be implemented (Howlett, Ramesh, and Perl 2009, 139). While policy entrepreneurs outside of government play a substantial role in the agenda-setting and policy formulation phases, decisions ultimately are made by state actors. Public policy decisions come in three dominant forms: positive decisions, negative decisions, and non-decisions (Howlett, Ramesh, and Perl 2009, 140-141). Positive decisions reflect choices that alter the status quo. The decision to invest in assisted living while disinvesting in LTC in BC is one example of a positive decision. Negative decisions reflect making a conscious choice to uphold the status quo. Negative decisions are difficult to identify, but occur when a government recognizes a problem, considers the policy alternatives, and decides that the status quo is appropriate. Non-decisions, on the other hand, occur when policymakers are either unaware of, or deliberately ignore the need to act on a particular issue (Howlett, Ramesh, and Perl 2009, 142).

Naylor (1999) describes the path of Canadian healthcare reform as largely incremental. The incremental decision-making model confronts the bargaining and compromise inherent to policy decision making and limits decisions to those that are politically and technically feasible under current conditions. Under an incremental model,
change occurs slowly and in relatively small increments (Howlett, Ramesh, and Perl 2009, 148). In an incremental model, the current political dogmas that inform the policy discussion are unlikely to be challenged and will have significant influence on the policy decisions that are undertaken. It is useful, then, to revisit the four political issues (Canada Health Act and the tyranny of the acute; aging in place philosophy; market-based solutions; cost containment) outlined in the agenda setting phase, and examine how these ways of thinking may influence decisions to undertake the various LTC policy options.

As a policy option, investing in new public LTC beds is limited by the fact that LTC is not an insured service that governments are legally obligated to provide and that it does not square well with the philosophy of aging in place. LTC also costs more to deliver than alternatives like home care and assisted living, so it does not align with the philosophy of bending the cost curve. Given the focus on private sector involvement, governments are most likely to rely on the private sector to build new infrastructure rather than invest in completely publicly financed facilities, although some jurisdictions, like Newfoundland, have bucked this trend.

Alternatives to LTC such as home care and assisted living are also not insured services, and this may negatively affect the decision to invest in them. However, alternatives to LTC more closely align with aging in place philosophy and, because they are less expensive than LTC, they partially meet the criteria of constraint of health spending. The private sector is also heavily involved in the home care and assisted living sectors, and governments could choose to contract out to improve supply of these services instead.
LTC funding reform squares well with all of the political priorities. It does not necessitate new spending on uninsured services and it does not change the public/private mix of services, merely how these services are funded. It also indirectly supports aging in place by helping to remove cream-skimming from LTC admissions, which may delay “premature admissions” to LTC.

A private insurance scheme also squares well with all of the political priorities. It does not necessitate new government spending since it is a market-based solution, and it could potentially support aging in place if benefits could be used toward services such as home care and assisted living in addition to LTC. A public insurance scheme does not fare as well in this regard, as it necessitates the creation of a new bureaucracy and new spending. Like a private scheme, it may support aging in place and private sector involvement if the benefits can be used to purchase LTC alternatives and services from private providers. The private savings option also aligns well with the political priorities.

It is important to note that these options are not mutually exclusive, and that governments could choose to invest in one, more than one, or all of these. In fact, it is likely that more than one of these reforms will be necessary to improve capacity in this sector. Ontario and Manitoba, for example, acknowledge the future need for more LTC beds even though there may be debate about the exact number required and whether those should be public or private. Alberta and Ontario have already experimented with LTC funding reform, and there is certainly evidence of interest in exploring similar reforms in other provinces (CIHI 2013). Private long-term care insurance products exist nationwide, and governments are considering their value and how they can encourage uptake.
Chapter 4: Policy Directions in British Columbia, Manitoba, and Ontario

British Columbia, Manitoba, and Ontario are three provinces who have adopted different approaches to LTC investment and as such present natural policy experiments in the Canadian context. British Columbia is the only province in Canada that has used assisted living as a replacement for conventional LTC. Additionally, as the BC Liberal Party has remained in power since 2001, this policy has been maintained more or less intact for over a decade. The uniqueness and longevity of this policy make it an ideal comparative case study.

Manitoba represents a unique provincial case because of the policy legacy of the Manitoba Home Care Program, the oldest and one of the highest funded public home care programs in Canada. While reliable data on provincial data on home care spending are notoriously elusive in Canada, the most recent available comparative evaluation showed that, in 2002-2003, Manitoba was second only to New Brunswick in per capita spending on home care at $144 per provincial resident (CIHI 2007). Manitoba’s long-standing, continuous investment in home care makes it a relevant policy case study, as it may shed light on the claim that “upstream” investment in home care can help to curb costs in the “downstream” LTC sector.

In this analysis, Ontario acts largely as a control, as there has not been a substantial policy shift toward one specific part of the continuing care continuum. However, there are a number of unique features of Ontario’s continuing care system that merit mention. Ontario is the only province in the three case studies examined here where the role of short-term respite care as a means of delaying LTC admission is mentioned in planning documents. It also has a large degree of private sector involvement in all
aspects of the continuing care continuum: Continuing Care Access Centres act as purchasers of largely private home care services, assisted living is delivered predominantly in private retirement homes, and 53% of LTC facilities are privately owned (Ontario 2013; McGrail et al. 2012; CUPE 2009). Ontario is also the only province in Canada that has a public reporting mechanism for LTC quality, although it is likely too soon to speculate about whether or not this has had an impact on quality of care in the province.

In addition, all three provinces also provide data from the RAI-MDS to CIHI for aggregation and analysis thereby making it possible to compare these provinces on indicators of LTC quality (Chapter 5). The percentage of older adults as a share of total population in each province has also grown since 1990. Residents aged 65 years and older now make up 17% of British Columbia’s population, an increase of 4.4% since 1990 that matches the national average increase. The growth in this segment of the population is slightly below the national average in Ontario at 4.3% since 1990, with 15.6% of the population currently aged 65 and older. Population aging is unfolding slower in Manitoba, as the 65-plus population is 14.6%, representing a 1.4% increase since 1990 (Statistics Canada 2014b). This chapter discusses the respective policy decisions since 1990 and compares the effects of these choices on the continuing care sector in each province.

**British Columbia**

In 1990, Premier Bill Vander Zalm’s Social Credit government initiated the Royal Commission on Health Care and Costs (referred to as the Seaton Commission) to study the British Columbia health system and recommend possible reforms. In 1991, the Seaton
Commission released a two-volume report entitled *Closer to Home*, which recommended a variety of reforms, including regionalization and a shift from acute to continuing care provided in the community (British Columbia 1991; Weaver 2006).

Two years later, under the NDP government of Mike Harcourt, a strategic plan entitled *New Directions for a Healthy British Columbia* was released by the Ministry of Health. The reforms outlined in *New Directions* were quite explicitly influenced by the findings of the Seaton Commission, including a commitment to regionalization (Weaver 2006). *New Directions* outlined the government’s intent to foster greater community orientation to wellness, including greater emphasis on continuing care (Davidson 1999).

A study testing the claim that regionalization had brought services “closer to home” was released by the Canadian Centre for Policy Alternatives in 2000. The study showed that, despite the rhetoric around continuing care in *Closer to Home* and *New Directions*, access to LTC and home care had actually declined throughout the mid-to-late 1990s. The report noted that while no LTC beds had been closed, the government had also not kept up with demand created by an aging population, and this led to downward pressures throughout the system. Home care, in addition to being diverted to post-acute clients because of shorter hospital lengths of stay, was also being provided disproportionately to frail seniors who no longer had access to LTC beds (Vogel 2000). This issue, in combination with an increase in ALC days in hospitals, drew both media attention and a pledge from the BC Liberal Party to build 5000 new non-profit LTC beds in the official platform of in the 2001 election campaign (Vogel 2000).

When the Liberals swept to power in 2001 under Gordon Campbell, the Ministry of Health initiated a major reform known as Continuing Care Renewal to substitute
assisted living for LTC. In assisted living settings in BC, the individual resides in a rented residence and is financially responsible for any services or care that the RHA does not provide. This is in contrast to LTC, where the RHA is responsible for all services and care provided to residents, and residents pay a per diem rate based on their financial means. The amount that the BC government directly pays for LTC is $125 per day per resident, while assisted living costs the public purse only $50-75 per day per resident. This policy shift resulted in the closure of over 3000 residential care beds in 2002 (Cohen et al. 2005).

In addition to the shift towards assisted living, the BC government also initiated two significant policy changes to residential care in 2002. First, continuing a policy shift toward the use of private capital in infrastructure projects begun in the late 1990s, the government introduced a requirement that all new LTC facilities under the purview of the RHAs (including private, not-for-profit and private, for-profit facilities, be sourced through a formal request for proposal (RFP) process. The process for constructing a new LTC facility prior to regionalization involved the government investing capital and providing know-how to largely non-profit groups. However, critics note that the RFP process is both time and labour-intensive and, as such, favours large private corporations or large, well-funded not-for-profits (Cohen, Tate, and Baumbusch 2009). Second, the eligibility criteria for admission to a LTC bed were increased such that only those with high levels of complex disability and who are unable to provide consent on their own behalf are eligible for public subsidies (Cohen, Tate, and Baumbusch 2009). In 2012, the eligibility criteria were revised to be more specific, and in order to be eligible for a subsidized LTC bed, clients must: 1) have severe behavioural problems on an ongoing
basis, or 2) have moderate to severe cognitive impairment, or 3) be physically dependent with needs that necessitate 24 hour nursing care, or 4) be clinically complex with multiple disabilities or comorbidities that require specialized skilled care from a variety of health professionals (British Columbia 2012).

A 2008 report by BC’s Auditor General was critical of the provincial government’s leadership in the continuing care sector. Auditor General John Doyle also concluded that the Ministry of Health was not “adequately fulfilling its stewardship role in helping to ensure that the home and community care system has the capacity to meet the needs of the population.” Doyle pointed out that the Ministry needed to better plan for future capacity in all aspects of home and community care, collect more detailed data for planning purposes, and be more transparent in their reporting of this data to the public.

Doyle’s report also emphasized the need to harmonize legislation covering LTC facilities in BC (BC Auditor General 2008). Indeed, while the majority of BC’s LTC facilities are licensed under the Continuing Care and Assisted Living Act, about 29% of facilities are actually licensed as private hospitals under the Hospital Act. There are important but subtle differences between these two pieces of legislation. Facilities licensed under the Hospital Act are not subject to random inspection and are not required to follow standardized incident reporting protocols for LTC facilities. The Hospital Act also requires that all prescription and non-prescription drugs be provided at no extra cost to residents. While residents in facilities licensed under the Continuing Care and Assisted Living Act have all or most prescription medications covered by provincial pharmacare, they are expected to pay for non-prescription medications out of pocket (BC Ombudsperson 2012).
A 2012 report by the BC Ombudsperson also raised concern about this discrepancy in the legislative framework, recommending harmonization of the benefits and protections available to all LTC residents. Among 176 recommendations for BC’s home and community care system, the Ombudsperson also suggested that the Ministry of Health establish a consistent method for determining the funding of LTC facilities and work with the RHAs to determine if the existing budget for residential care is sufficient to meet population needs (BC Ombudsperson 2012).

In response to the Auditor General and Ombudsperson’s reports, the BC government released a report entitled Improving Care for BC Seniors: An Action Plan. While this plan did directly address some of the Ombudsperson’s recommendations, including a pledge to standardize benefits to all LTC residents regardless of where they receive care which was achieved by February 2013, it did not represent a substantial change of course from the 2001 reforms (BC Ombudsperson 2013; British Columbia 2012). While there is evidence that in some RHAs the focus has shifted away from assisted living and back to LTC, the policy legacies of the Continuing Care Renewal of 2001-2002 are reflected in the fact that in 2008, BC had the lowest number of residential care beds (including LTC and assisted living) per 1000 adults aged 75 and older.

Manitoba

Continuing care in Manitoba exists largely in the policy legacy of Canada’s first coordinated provincial home care program. The Manitoba Home Care Program, begun in 1974, was operated by Manitoba Health prior to regionalization and is now under the purview of the RHAs. The Manitoba Home Care Program still acts as the single point of entry to other continuing care services, such as LTC and assisted living (Banerjee 2007).
The most significant policy reform of Manitoba’s continuing care system occurred in 2006 with the release of a strategy entitled *Aging in Place*. Similar to the 2001-2002 reforms in British Columbia, *Aging in Place* focused quite heavily on assisted living and supportive housing models. It proposed that over 5 years, 1100 spaces would be created that allow for community-based care. Primarily based around community housing, this plan included services to be provided to seniors in community settings who do not require 24 hour care (assisted living) as well as the creation of additional capacity in publicly subsidized supportive housing. *Aging in Place* also focused on the delivery of special home supports for seniors who are high users of the acute care system and would otherwise be eligible for placement in LTC (Manitoba 2006).

While *Aging in Place* followed the British Columbia example in investing in assisted living, it also included an $80 million commitment to capital investment in LTC in the construction of new facilities and the renovation of existing ones. Perhaps reflective of the growing acceptance of positive aging, the rhetoric within and around *Aging in Place* focuses largely on providing “choices”, “options”, and “freedom” for seniors, rather than merely delaying admission to LTC (Manitoba 2006). As previously noted, a 2011 report by the Manitoba Centre for Health Policy found that there will be a substantial increase in the need for LTC beds in the province by the year 2030. However, the authors also suggest that some of this need can be met through supportive housing, if “the current philosophy of supportive housing [changes] considerably, to accept sicker people” (Doupe et al. 2011). This statement suggests that the substitution effect of assisted living for LTC many experts described in British Columbia has not yet materialized in Manitoba. Manitoba has also initiated an *Aging in Place* Working Group
to assess whether the program is meeting the needs of the population. The first report of this Working Group was delivered in 2011 (Manitoba 2011).

**Ontario**

Ontario’s 14 Local Health Integration Networks (LHINs), introduced in 2007, are responsible for the allocation of funding for hospitals, community support services organizations, community mental health and addictions agencies, community health centres, and LTC facilities. Community Care Access Centres (CCACs), the entities that purchase, coordinate, and manage publicly-subsidized home care services within a defined geographic area, also fall under the purview of the LHINs (Born and Laupacis 2012; Ontario 2013). The CCACs also act as a single point of entry to LTC and assistive living/supportive housing. Some assisted living services are made available in Ontario to older adults who are frail or cognitively impaired and have greater care needs than can be met by scheduled home care visits, but do not require 24 hour care (Ontario 2013).

One of the first strategic initiatives related to continuing care undertaken after the LHIN system was introduced was Ontario’s *Aging at Home* strategy, introduced in 2007. This strategy initially represented a $1.1 billion investment in an integrated continuum of home and community-based services aimed at keeping seniors in their homes and out of acute care and LTC. An independent review of care and staffing standards in LTC homes to be undertaken by Shirlee Sharkey, President and CEO of Saint Elizabeth Health Care, a not-for-profit home care provider, was also launched in 2007. Released in 2008, Sharkey’s report, entitled *People Caring For People: Impacting The Quality of Life and Care of Residents in Long-Term Care Homes*, provided a variety of recommendations, including enhancements of staff capacity, targets for daily care time from a variety of
care providers, improved quality measurement, and public reporting on LTC quality (Sharkey 2008).

While Aging at Home represented a shift toward care provided at home, concerns were being raised about whether or not CCACs were ensuring that community needs were being met in an efficient and equitable way. A 2010 Auditor General’s report found that even though the CCACs were now under the governance of the LHINs, funding was still based on historical levels rather than population needs (Ontario Auditor General 2010). This funding approach combined with a procurement freeze since 2008, were identified as contributing to variation in services, waitlists, and quality across the province (Born and Laupacis 2012).

LTC ownership has been an issue of interest in Ontario. A 2005 study found that ownership characteristics were related to resident profile, as residents of government-owned facilities required higher intensity nursing care, and private, not-for-profit facilities (those owned by religious orders or charities) had a higher proportion of residents over the age of 85. Private, for-profit facilities licensed by the Ministry of Health and Long-Term Care generally served younger residents that required lower service intensity (Berta, Laporte, and Valdemanis 2005). While those authors cautioned that delayed entry to LTC was causing an increased homogeneity of care needs among LTC residents regardless of facility ownership, a 2013 investigation by the Toronto Star suggests that there are still some discrepancies in demand on this basis. Private, not-for-profit facilities make up only 25% of the beds in Ontario, but 42% of applicants to LTC request them as their first choice of home. Private, for profit facilities, which comprise 58% of beds, are the first choice of 32% of applicants, while public facilities, which
comprise 17% of beds, are the first choice of 26% of applicants (Boyle 2013). This suggests that public perception of care provided in different settings may act as a barrier to system integration.

ALC has also been a significant concern in Ontario. A 2011 report by Dr. David Walker, the provincial lead for ALC, made a number of recommendations about how LTC and home care policies could aid in the reduction of ALC in the province. Walker recommended optimizing and differentiating LTC capacity, including enhanced capacity in special care units for clients with high or specialized needs (such as dementia), ensuring that the geographic distribution of LTC beds meets community needs, and increasing the number of short stay, respite and rehabilitation care beds. On home care, Walker recommended enhancing home rehabilitation programs in order to allow clients access to this care outside of hospital (Walker 2011). These recommendations, along with an additional call for more effective home and community care, were echoed by Don Drummond in his recent report on the reform of Ontario’s public services (Drummond 2012).

Ontario’s recently released seniors strategy, entitled Living Longer, Living Well, reiterates many of the previous concerns about ALC and access to home care. While the Ontario strategy stops short of recommending an increase in the absolute number of LTC beds, it does recognize the growing need for more complex care in LTC as residents are admitted later in life with more care needs than in the past. Living Longer also recommends an increased capacity of respite and short-stay beds in order to facilitate older adults moving out of acute care beds faster (Ontario 2013). While the strategy does not explicitly recommend increasing LTC capacity in the short-term, lead author Samir
Sinha was quoted in a 2013 Toronto Star article as saying that there is “no question” that Ontario will need to build more facilities in the future (Boyle 2013).

Ontario Budget 2013 also included an annual funding increase of 2% to LTC facilities for direct resident care (Ontario 2013). Additionally, Health Quality Ontario in conjunction with the LHINs have embarked on an LTC quality improvement initiative called *Residents First*, which aims to train LTC staff to provide safe, effective, and responsive care (Health Quality Ontario 2013). *Residents First* has also made the public reporting on LTC quality recommended in the Sharkey Report a reality.

**Comparison**

To compare the continuing care programs in each of these provinces, a comparative public policy approach was used. Richard Rose (2005) states that, when comparing programs across jurisdictions, one should first create a model that describes how the programs work. The essential descriptive elements to an effective model include laws and regulations, organization responsible, personnel, how the program is financed, program outputs, program recipients, and program goals (Rose 2005).

Rose’s (2005) conceptualization of a comparative public policy model was originally designed for drawing cross-national lessons. In applying this concept to provincial comparisons, some of the essential elements described by Rose do not apply as there will not be variation between provinces. Personnel required to deliver continuing care, for example, will be largely the same across provinces (e.g. nurses, care aides, and other allied health professionals). While costs to clients may vary across provinces, the portion paid by governments for continuing care is funded through general taxation and in part from the federal Canada Social Transfer in every province. Although terminology
and criteria may vary slightly, the program recipients (older adults who require supportive care and individuals with physical or cognitive disabilities) and program goals (to provide supportive care to individuals with sub-acute health concerns that can be treated outside of hospital) are largely the same across provinces.

Six program elements will be used to compare the continuing care programs in these three provinces. These elements are: preferred care option in policy planning, regulation and governance of LTC, assisted living, and home care, LTC quality measurement and standards, and LTC ownership. These are shown in the proceeding table (Table 3.1). Legislative frameworks for the assisted living sector in these three provinces are shown in Table 3.2.
<table>
<thead>
<tr>
<th>Program Element</th>
<th>British Columbia</th>
<th>Manitoba</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred care option in policy planning</strong></td>
<td>Assisted living</td>
<td>LTC</td>
<td>Status quo (with enhanced respite care options)</td>
</tr>
<tr>
<td><strong>LTC administration</strong></td>
<td>Single entry point with rigid eligibility criteria, administered by RHAs</td>
<td>Single entry point administered by Manitoba Home Care Program</td>
<td>Single entry point administered by Community Care Access Centres (CCACs)</td>
</tr>
<tr>
<td><strong>Assisted living administration</strong></td>
<td>Single entry point administered by RHAs. Regulated through Assisted Living Registrar. Care standards exist. Government funds 1.5 hours of care (personal support or health care) per day per resident.</td>
<td>Single entry point administered by RHAs. No other regulation or care standards apply.</td>
<td>No single entry point. Assisted living largely takes place in private, unregulated retirement homes.</td>
</tr>
<tr>
<td><strong>Home Care administration</strong></td>
<td>RHAs administer and deliver.</td>
<td>Manitoba Home Care Program administers a standard program which is delivered by RHAs.</td>
<td>Community Care Access Centres administer and deliver, as purchasers of private home care services.</td>
</tr>
<tr>
<td><strong>LTC quality measurement and standards</strong></td>
<td>RAI-MDS is required. Resident’s Bill of Rights outlines quality standards.</td>
<td>RAI-MDS is required.</td>
<td>RAI-MDS is required. Public reporting on LTC quality is done by Health Quality Ontario.</td>
</tr>
<tr>
<td><strong>Ownership of LTC facilities (CUPE 2008)</strong></td>
<td>31% private, for profit.</td>
<td>26% private, for profit.</td>
<td>53% private, for profit.</td>
</tr>
</tbody>
</table>

Table 4.1. A comparative model for continuing care programs in British Columbia, Manitoba, and Ontario.
<table>
<thead>
<tr>
<th>Province</th>
<th>Term Used</th>
<th>Specific Legislation Exists?</th>
<th>Funding for Health/Personal Care Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC</td>
<td>Assisted living</td>
<td>Yes; <em>Community Care and Assisted Living Act</em></td>
<td>Yes; 1.5 hours per tenant per day; $65 per day per tenant for personal care</td>
</tr>
<tr>
<td>MB</td>
<td>Supportive housing</td>
<td>No; <em>Social Services Administration Act</em>, <em>Residential Tenancies Act</em></td>
<td>Yes, if admitted through single entry point</td>
</tr>
<tr>
<td>ON</td>
<td>Supportive housing</td>
<td>No; <em>Residential Tenancies Act</em></td>
<td>Yes; personal support and homemaking services provided, access to home care through CCAC.</td>
</tr>
</tbody>
</table>

Table 4.2. An overview of assisted living frameworks in British Columbia, Manitoba, and Ontario. Source: (McGrail et al. 2012).
In terms of the six program elements, a number of significant differences exist. With regard to LTC administration, while all provinces use a single entry point system that requires those potentially in need of LTC to be assessed by a case coordinator, BC is the only province with rigid clinical criteria that must be met in order to qualify for publicly-subsidized LTC. BC is also the only province that funds a defined number of hours of care per resident per day in assisted living. Ontario’s use of CCACs as the purchaser of home care services is unique among these provinces, as home care provision is the domain of the RHAs in the other provinces. With regard to quality and safety reporting, BC’s use of a resident Bill of Rights is an innovative step in communicating to residents and their families what care standards should be upheld. Ontario’s public reporting on standard LTC quality indicators (which will be examined in more detail in Chapter 6) takes this one step further and allows residents and their families to compare clinical outcomes from one facility to another.

In all provinces, concerns have been raised about access to LTC services. This discussion has been most visible in British Columbia, where the Auditor General, Ombudsperson, and the provincial branch of the Canadian Centre for Policy Alternatives have all raised concerns about how the provincial health system is responding to the demands of an aging population. In Manitoba, where new LTC beds have been committed to, there has been some focus on the appropriateness of LTC admissions, with the aim of ensuring that clients who could better be cared for outside of LTC have this opportunity. However, a recent analysis showed that only about 1 in 8 LTC clients could potentially be cared for in an assisted living setting (Doupe 2013). Although this certainly presents an opportunity to shorten LTC wait times and improve access, it is still likely
that demand will far outpace supply. In Ontario wait times and access are also a concern. New LTC beds have been built, and there have been substantial commitments across the care continuum, but experts warn that the province will need to address the LTC bed shortfall in the future (Boyle 2013).

LTC policy change has been dramatic in BC and comparatively more incremental in Ontario and Manitoba. Whether the policy changes have brought about the desired results, however, remains an open question. In the chapters that follow, data will be analyzed to begin to address the impact of this policy change on cost containment and care quality in each province.
Chapter 5: LTC Spending Trends

This chapter examines trends in British Columbia, Manitoba, and Ontario’s spending on LTC since 1990 using a variety of metrics, including per capita total, provincial government, and private source (largely out-of-pocket payment) spending. It also examines the extent to which private source spending has grown relative to provincial government spending. Trends in the percentage of government health expenditure directed to LTC are also explored, and compared to the trend in acute care spending.

The purpose of taking a closer look at the spending data is twofold. First, these data will show the extent to which governments are investing or disinvesting in LTC, and if these trends correspond to increases or decreases in private expenditure on LTC. Second, it will allow for broad inferences about the effect that policy choices, such as BC’s shift toward assisted living, have on macro-level LTC spending. Spending data from the Canadian Institute for Health Information’s National Health Expenditure Database are used. In this database, ‘Other Institutions’ includes all residential care facilities for the chronically ill or disabled which are licensed and funded by provincial ministries, most often health or social services (CIHI 2013a). Although this definition encompasses facilities that provide care for non-elderly individuals with physical and cognitive disabilities, LTC for the elderly makes up the vast majority of facilities included in this category. As such, ‘Other Institutions’ can reasonably be used as a proxy for total spending in the LTC sector, with the important caveat that not every dollar in this category goes toward the care of older adults.
Figure 5.1 shows the total per capita expenditure on Other Institutions in British Columbia, Ontario, and Manitoba from 1990 until 2013. This total expenditure includes public spending, the vast majority of which comes from provincial governments with small amounts also being contributed by municipal governments and the federal government, and private spending, which includes payments made out-of-pocket and through private insurance. Of note is the fact that total spending patterns in Ontario and Manitoba have been very similar, resulting in total per capita spending that is nearly three times what it was in the baseline, pre-regionalization year of 1990. Spending in both Ontario and Manitoba has also been steadily increasing since 2000. Total per capita spending in British Columbia, on the other hand, peaked at a value of $460.16 in 2002 and has mostly been declining since then. Although the 2012 and 2013 forecasts show a small projected increase in British Columbia, this will not be confirmed until the final figures are available. Since 1990, total per capita spending in British Columbia has grown at a rate that is roughly half of the rates in Ontario and Manitoba.
Figure 5.1. Per capita total expenditure (public and private) on Other Institutions, 1990-2013.
Figure 5.2 shows provincial government expenditure on Other Institutions from 1990-2013. Again, spending in Manitoba and Ontario has followed similar patterns since 1990. Provincial government spending in Manitoba increased by a factor of 2.6, and increased in Ontario by a factor of 2.7. In British Columbia there has been a notable decrease in provincial spending since 2002, and projected 2013 spending levels have nearly returned to what they were in 1990, representing a factor of increase of only 1.04. This period of disinvestment since 2002 corresponds with the Campbell government’s introduction of assisted living as a substitute for LTC.
Figure 5.2. Provincial government expenditure on Other Institutions, 1990-2003.
Figure 5.3 shows private expenditure on Other Institutions since 1990. Private expenditure includes out-of-pocket payments and payments made through private insurance. While private expenditure on residential care is increasing in all of the provinces studied, it is of note that it is increasing at the fastest rate in British Columbia, particularly since 2005. It is also important to note that this has taken place over a period of decreasing public spending on LTC in British Columbia.
Figure 5.3. Private expenditure on Other Institutions, 1990-2013.
Figures 5.4, 5.5, and 5.6 show comparisons of provincial government and private expenditure on Other Institutions for each province since 1990. In Ontario, provincial and private spending are growing at roughly the same rate. In Manitoba, provincial spending has, in recent years, increased slightly faster than private spending, though both are growing. In British Columbia, however, there has been a convergence as, since about 2002, provincial spending has decreased and private spending has increased. When calculated from the total spending on LTC from all sources, private spending in BC accounts for 45%, compared to 34% in Ontario and only 23% in Manitoba.
Figure 5.4. Provincial government vs. private expenditure on Other Institutions, Ontario, 1990-2013.
Figure 5.5. Provincial government vs. private expenditure on Other Institutions, Manitoba, 1990-2013
Figure 5.6. Provincial government vs. private expenditure on Other Institutions, British Columbia, 1990-2013.
Figure 5.7 shows provincial government spending on Other Institutions as a percentage of total health spending. The percent of total spending on residential care in Ontario and Manitoba has been relatively stable, with a modest 1.5% increase since 1990 in Ontario and a small decrease of 0.6% in Manitoba. The percentage spent on residential care in BC has dropped precipitously since 1990, with a 7% decrease since 1990. Even more striking is the fact that LTC spending in British Columbia peaked in 2002 at 15.3%, the year of the Campbell government’s Continuing Care Renewal policy intervention, and has dropped nearly 10% since then.

Acute care is used as a point of comparison to another health sector. Figure 5.8 shows provincial government spending on hospitals as a percentage of total health spending. As would be expected, all three provinces experienced decreases in hospital spending as a percentage of total health spending during the 1990s, at least in part as a result of a fiscal climate that resulted in decreases to federal transfer payments and rural hospital closures across many provinces. This was followed by stabilization in the 2000s. BC, unlike the other two provinces, has seen a gradual increase since 2005, and, as a percentage of total health spending, hospital spending has returned to 1990 levels.
Figure 5.7. Percent of total provincial government health spending on Other Institutions, 1990-2013.
Figure 5.8. Percent of total provincial government health expenditure on hospitals, 1990-2013.
Analysis

It is important to note that private expenditure on LTC has grown in all three provinces since 1990, which is likely indicative of the rising cost of LTC to residents, and the growth of the private, for-profit sector. The trend toward cost shifting from government to individual users seems strongest in British Columbia, where private source spending has grown at a time of provincial government disinvestment in LTC. However, despite a dramatic increase since the Continuing Care Renewal was initiated, BC’s per capita private spend ($166) was still lower than Manitoba’s ($184) and Ontario’s ($201).

It may also be tempting to conclude from these data that BC, as the only province where provincial government spending has decreased since 1990, has successfully bent the LTC cost curve. However, as described in Chapter 1, inadequate continuing care capacity can contribute to pressures elsewhere in the health care system. The fact that the percentage of total health spending that is directed towards hospitals in BC has returned to 1990 levels while decreasing in Manitoba and Ontario may indicate that some of the cost savings achieved by the Continuing Care Renewal have been offset by factors such as ALC and longer inpatient lengths of stay for seniors.

Defining an appropriate benchmark level of per capita government spending on LTC is likely not possible given the contextual differences between provinces. Differences in population-level health and socioeconomic status, population distribution, and rates of population aging exist. The costs of inputs such as capital costs, wages paid to LTC staff, and utilities also vary between provinces. However, analyzing the impact of policy changes on spending is important in testing the claims and assumptions associated with the policies in question. It is also important to ask what the level of investment in
LTC is buying, in terms of the quality of and access to care, as will be explored in the chapters that follow.
Chapter 6: Quality of Care in LTC

LTC quality is another area of substantial policy interest. While providing care that is safe, high quality, and person-centred can be seen as a moral imperative, the movement toward the measurement of quality and patient safety in North American health care traces its roots to two key events in health policy that unfolded in the United States. The first was the 1991 founding of the Institute for Healthcare Improvement by, among others, Dr. Donald Berwick. The second was a report entitled To Err is Human, released by the Institute of Medicine in 1999, which built on the Institute for Healthcare Improvement’s work, focused on the processes leading to medical errors and unsafe patient care (Institute of Medicine 1999; Forest 2014). In Canada, the groundwork was also laid for the evaluation of quality and patient safety in the 1990s with the founding of CIHI in 1994, and the Canadian Health Services Research Foundation (since renamed the Canadian Foundation for Healthcare Improvement) in 1996.

The quality and patient safety “revolution” is still very much underway (Forest 2014), and governments and research organizations have begun to evaluate quality of care outside of hospitals, and in particular in LTC. CIHI’s Continuing Care Reporting System, for example, provides comparable data on a variety of quality indicators that policymakers and health system managers can use to evaluate performance (CIHI 2013c). As previously noted, Health Quality Ontario has focused on care standards for LTC and is the first organization to report publicly on LTC quality at the facility level. Quality is of particular interest to governments because it is an issue that has a direct impact on the general public. Discussing quality resonates with policymakers and the general public
because it relates to the individual experience in LTC and how the care provided to our older loved ones can be made safer and more effective.

Although there is disagreement on its precise definition, quality has been widely discussed and studied by a variety of policy actors and advocates. A number of policy levers have been suggested for provincial governments to improve LTC quality, including legislating minimum staffing levels, re-examining governance, management, and delivery models, and standardizing education levels for unregulated providers like care aides (Jansen 2011). Some research, summarized in McGregor and Ronald (2011) and Jansen (2011), has also shown that, in some jurisdictions, private, for-profit facilities provide care that is of lower quality than that provided in public and private, not-for-profit facilities. As such, public sector union organizations have focused on slowing the proliferation of the private, for-profit LTC sector (see CUPE 2009).

It must be noted that much of the existing evidence around these policy levers has been generated by interest groups, in particular labour groups and pro-labour think tanks (Jansen 2011; CUPE 2009; Cohen 2012). Objective Canadian evidence in these crucial areas is currently limited, but it is growing. Legislated minimum staffing levels are an area of particular interest, at least in part due to the significant attention paid to them in Ontario’s Sharkey Report (2008).

It is beyond the scope of this research and publicly available data to speculate about the how factors like staffing, education, governance, and ownership affect quality as it is defined in this work. While the relationship between per capita public spending on LTC and LTC quality will be examined, it is important to note that there may be a number of confounding variables that are also involved in quality.
Data Source

Data for this analysis are taken from the Canadian Institute for Health Information’s Continuing Care Reporting System’s Quick Stats publication. The Continuing Care Reporting System is a database of demographic, clinical, functional, and resource utilization information on individuals receiving LTC services in Canada. This information is typically used by clinicians for care planning and quality improvement purposes, and by system managers and policy makers to support planning, quality improvement, financing and resource allocation decision making (CIHI 2014). Since it aggregates data at the provincial level for the fiscal years 2011 and 2012, the Quick Stats source precludes the measurement of intra-provincial variation either at the regional or facility level.

Not all provinces currently submit data to the Continuing Care Reporting System, and provinces that have only begun submitting data since 2011 are not included in the 2013 Quick Stats publication. Data coverage is good for two of the three included provinces. The data from Ontario represents 638 facilities from across the province with 101,112 residents who were assessed using the RAI-MDS. BC’s data covers 280 facilities from across the province and 27,734 assessed residents (CIHI 2013d).

Manitoba’s data is more limited, as it covers 38 facilities and 7337 assessed residents, all of which are in the Winnipeg Regional Health Authority (CIHI 2013d). The Winnipeg Regional Health Authority is Manitoba’s largest RHA and covers more than 700 000 of Manitoba’s 1.2 million residents (WRHA 2014; Statistics Canada 2012). However, given that the population covered is predominantly (although not entirely)
urban, these data may not be representative of the proportion of Manitoba’s population living in rural or remote communities.

**Comparing Provincial Resident Profiles**

Although using the risk-adjusted quality indicators is preferable in comparing LTC quality between provinces, it is still important to describe the demographic and clinical profiles of residents in each province. The LTC resident profile is, to some degree, policy amenable, in that governments can create eligibility criteria for admission to LTC and for public subsidy. As previously described, British Columbia has legislated eligibility criteria for admission to a publicly subsidized LTC bed as a means of rationing on the basis of need. While Manitoba and Ontario do not have legislated criteria, single entry point systems in these provinces require the assessment of care needs before individuals are admitted to publicly subsidized LTC.

In fact, the demographic and clinical profiles of LTC residents are strikingly similar in the three provinces of interest. The average age of residents was nearly identical, with Ontario having the youngest at age 82, Manitoba the oldest at 84, and BC in the middle at 83. There was also only slight variation in the percentage of residents who were classified as dependent or totally dependent in four activities of daily living (personal hygiene, toileting, locomotion, and eating). Ontario had the most dependent or totally dependent residents (35%), while Manitoba had 31.5% and BC had 32.1%. The proportion of residents with severe cognitive impairment was also quite similar: 28.8% in Ontario, 30.2% in Manitoba, and 32.4% in BC.

Resource Utilization Groups (RUGs) are standardized case-mix stratifications that group residents based on the types and intensities of care they are likely to receive (CIHI
For four of the seven RUGs, there are key differences between provinces. Ontario has substantially more clients who were classified as clinically complex (19.0%, compared with 11.2% in MB and only 1.2% in BC) and requiring special rehabilitation (17.5%, versus 0.8% in MB and 1.3% in BC). This difference may reflect the policy role Ontario’s LTC facilities play in providing short-term, convalescent or rehabilitative care. Ontario also has the smallest proportion of clients with reduced physical function (39.5%, compared with 53.2% in MB and 53.1% in BC) and impaired cognition (9.2%, versus 23.5% in MB and 22.5% in BC), areas in which there were very large differences between provinces.

**Indicator Selection**

Indicators for comparison have been selected as a result of their use in a recent CIHI report comparing the quality of Canadian nursing homes (CIHI 2013c). Indicators touch on three dimensions of the resident experience in LTC: physical function, quality of life, and safety.

These indicators are presented as a percentage (e.g. 10% of LTC residents in Ontario had worsened cognitive ability from baseline in 2011-12). Only percentages that have been risk-adjusted to account for the effect of a higher risk resident population are reported. That is, if one of the provinces of interest had significantly more LTC residents with high care needs than others, that province would almost certainly perform more poorly on the quality indicators. Risk-adjustment compares the risk profile of a provincial resident population to a standard reference population, then modifies the indicator results to be relative to that population (CIHI 2013f), allowing for more accurate quality comparisons.
Physical Function

*Maintained or improved transfer, wheeling, walking*

The Activities of Daily Living Hierarchy scale, which is part of the RAI-MDS assessment, is used to measure maintenance/improvement in transfer, wheeling, or walking. Transfer ability is the ability to move independently from a chair, bed, bathtub, or shower. Wheeling is included to reflect the fact that one can be independently mobile with the use of an assistive device (such as a four wheel walker) or wheelchair. Functional decline in older adults typically occurs in a specific order. Impairments in transfers and locomotion are considered mid-loss activities of daily living, as they typically present after difficulties with dressing and personal hygiene (early-loss activities of daily living) but before more serious impairments such as difficulties with feeding oneself and being mobile in bed (late-loss ADL) (Manitoba Centre for Health Policy 2011).

Maintenance or improvement in transfers, wheeling, and walking is an important indicator of physical function, as the ability to move about independently is an important determinant of quality of life and safety. Differences in this indicator may also speak to variation in restorative care practices (specific rehabilitative programs focused on improving or maintaining physical function) between individual facilities and jurisdictions (CIHI 2013c), although differences may also speak to changes in the clinical status of residents. A higher rate is indicative of better performance.
Figure 6.1. Maintenance or improvement in transfer, wheeling, and walking ability, 2011-2012.
In this indicator, as shown in Figure 6.1, there is little difference between provinces, with a variance of only two percent between the best performing province (BC) and the poorest (MB). This may be a result of the similarity in resident populations. In each province, as previously noted, more than 30% of the resident population were dependent or totally dependent in their activities of daily living, meaning they are currently not independent in mid-loss activities and could not reasonably be expected to improve.

Worsened bladder incontinence

This indicator is measured by worsened bladder incontinence over the past 90 days. Bladder incontinence can have a number of negative social and physical consequences. It may lead to social isolation, reduced mobility, and skin breakdown (CIHI 2013c). Incontinence is also associated with higher rates of falls and some specific associated fractures in LTC residents (Brown et al. 2000). Best practice guidelines exist for continence care, and interventions such as individualized toileting schedules and medication review can promote continence (Health Quality Ontario n.d.). A lower rate on this indicator is indicative of better performance. As shown in Figure 6.2, Manitoba performed best on this indicator, with only 12% of residents experiencing worsened bladder continence in 2011-2012.
Figure 6.2. Percentage of residents with worsened bladder incontinence, 2011-12.
**Quality of Life**

*Depression*

Depression is measured by a worsened mood over the past 90 days. Depression is not a normal part of aging, and is associated with declines in self-sufficiency and cognitive function. There are a number of pharmacologic and non-pharmacologic treatments for depression, and the worsening of depressive symptoms may, in some cases, indicate a failure to treat and manage the condition effectively. A lower rate on this indicator is indicative of better performance.

As shown in Figure 6.3, Manitoba performed best on this indicator, with only 11.7% of residents experiencing worsened mood from symptoms of depression, compared with 17.5% in BC and 25.9% in Ontario, a substantial difference between provinces.
Figure 6.3. Percentage of residents with worsened mood from symptoms of depression, 2011-2012.
Worsened behavioural symptoms

This indicator is measured as worsened behavioural symptoms in the previous 90 days. The symptoms are measured by the number of documented challenging behaviours, including wandering, verbal or physical abuse, and socially inappropriate behaviours.

This indicator is important in terms of quality, as behavioural symptoms present a quality of life challenge for the resident, other residents in the facility, as well as staff members. Evidence-based interventions are available to help deal with behavioural symptoms using non-pharmacologic means, so this is, to some degree, amenable (CIHI 2013c). A lower rate on this indicator is indicative of better performance. As shown in Figure 6.4, Manitoba again performed best on this indicator, with only 6.3% of assessed residents having worsened behavioural symptoms.
Figure 6.4. Percentage of residents with worsened behavioural symptoms, 2011-12.
Worsened Pain

This indicator is measured by worsened frequency and intensity of pain (as measured by the interRAI Pain Scale, which is part of the RAI-MDS assessment) within the past 90 days. Pain can have a significant negative impact on quality of life, including on sleep, emotional state, and social connectedness (CIHI 2013c). A lower rate on this indicator is indicative of better performance. As shown in Figure 6.5, Manitoba again had the best performance, with 7.2% of residents with worsened pain, compared with 10.7% in BC and 11.1% in Ontario.
Figure 6.5. Percentage of residents with worsened pain, 2011-12.
Safety

Falls

This indicator is measured by a fall in the previous 30 days. Falls are an important cause of injury and death among older adults, particularly those in LTC. A fall can result in injury that leads to impaired physical function, and fear of falling, a psychological construct often brought on by a fall, can significantly impact quality of life (CIHI 2013c). A lower rate on this indicator is indicative of better performance.

As shown in Figure 5.6, Ontario performed best on this indicator with 13.9% of assessed residents having fallen in the past 30 days, compared with 15.3% in BC and 16.6% in Manitoba. There was little variation between these provinces, with only 2.7% separating the best performer from the poorest. It is worth noting, however, that Ontario had the lowest proportion of residents classified by RUG as having impaired physical function or impaired cognition, both of which are associated with increased fall risk.
Figure 6.6. Percentage of residents who had fallen in the past 30 days, 2011-12.
Inappropriate use of antipsychotic medications

This indicator is measured by the percentage of residents without a record of schizophrenia, Huntington’s disease, or hallucinations receiving an antipsychotic medication in the previous 90 days. With the exception of one specific drug (risperdone), this class of drugs is not approved for treatment of the symptoms of dementia. Since 2005, Health Canada has mandated that a warning about an increased risk of all-cause mortality associated with the use of these drugs in individuals with dementia (Health Canada 2005). In addition to the increased risk of mortality, recent evidence suggests that antipsychotic medication use in this population can lead to a variety of adverse reactions and events, including impaired physical and mental function, and injurious falls (Banerjee et al. 2011). A 2009 analysis-in-brief from CIHI showed that these drugs are accessed through public drug plans at rates that are far above the prevalence of the mental disorders they are approved for use in (CIHI 2009). A recent study of a small sample of long-term care residents with dementia in Western Canada also showed that 88% were given at least one of these drugs inappropriately according to evidence-based clinical guidelines (Harris 2012). A lower rate on this indicator is indicative of better performance.
Figure 6.7. Percentage of residents with inappropriate use of antipsychotics, 2011-12.
Again, as shown in Figure 6.7, Manitoba was the best performer of the three provinces, with a rate of inappropriate use of antipsychotics of 25.6%. It is notable, however, that all provinces were have relatively high rates of inappropriate use of these drugs, meaning that they are likely being used to manage behavioural symptoms in residents, particularly those with dementia. The prevalent use of inappropriate antipsychotics poses a significant safety risk to LTC residents. Since the problem is highly amenable to policy intervention, it should be addressed by governments in the future.

*Pressure Ulcers*

This indicator is measured by the presence of a new stage 2-4 pressure ulcer during the previous 90 days. Referred to more commonly as bed sores, pressure ulcers are caused by remaining in one position for a long period of time, and are more common in older adults who are unable to mobilize independently. Pressure ulcers are painful, lead to an increased risk of infection or even death, and, in most cases are preventable through proper care. Once developed, they are complex and expensive to treat (CIHI 2013c). A lower rate on this indicator is indicative of better performance. As shown in Figure 6.8, Manitoba also performed best on this indicator, although there was little variation between provinces.
Figure 6.8. Percentage of residents with a new stage 2-4 pressure ulcer, 2011-12.
Conclusions

Manitoba was the top performer in six of the eight quality indicators as shown in the summary in Table 6.1. These findings are potentially limited by the fact that population coverage for Manitoba included only the predominantly urban Winnipeg Regional Health Authority. Data from Ontario and BC were likely more representative of the entire provincial population, including rural residents. Although data at the regional level are not included in the publicly available Quick Stats, future research could compare performance on these indicators between urban and rural regions.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Category</th>
<th>Top Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsened depression</td>
<td>Quality of Life</td>
<td>MB</td>
</tr>
<tr>
<td>Worsened pain</td>
<td>Quality of Life</td>
<td>MB</td>
</tr>
<tr>
<td>Worsened behavioural symptoms</td>
<td>Quality of Life</td>
<td>MB</td>
</tr>
<tr>
<td>Maintain or improve ability to transfer</td>
<td>Physical Function</td>
<td>BC</td>
</tr>
<tr>
<td>Worsened bladder incontinence</td>
<td>Physical Function</td>
<td>MB</td>
</tr>
<tr>
<td>Fall in previous 30 days</td>
<td>Safety</td>
<td>ON</td>
</tr>
<tr>
<td>Inappropriate antipsychotic drug use</td>
<td>Safety</td>
<td>MB</td>
</tr>
<tr>
<td>New stage 2-4 pressure ulcer</td>
<td>Safety</td>
<td>MB</td>
</tr>
</tbody>
</table>

Table 6.1. Summary table of top provincial performers on each quality indicator.
Despite these data limitations, it is still striking that Manitoba emerged as the clear leader among these three provinces, all of which have similar LTC resident populations. It is possible that Manitoba’s strong performance on these indicators is a result of factors which are beyond the scope of this research, including staffing levels, models of care, facility design, and the existence of one of the longest-running and most comprehensive home care programs in the country. However, this may also be explained, at least in part, by the fact that Manitoba has, by far, the highest per capita public spending on LTC. This increased spending may have allowed Manitoba to “buy change” in this sector by investing in innovative approaches to improve the quality of care. Manitoba’s care quality practices in the LTC sector should be of interest to other provinces.

Ontario performed poorest on four indicators. Ontario’s comparatively poor performance may be related to the fact that, as previously noted, the province had the highest percentage of LTC residents who were dependent or totally dependent, though this difference was slight. Ontario also had the most clinically complex clients, and the most requiring special rehabilitation, which may be reflective of a population that is likely to see functional and health declines. However, Ontario also had the lowest proportion of residents with cognitive impairment, and the least with reduced physical function, clients who likely require more attention and staff time. BC was most often in the middle, having the best performance on only one indicator, but the worst on only two.

The fact that these differences exist between jurisdictions with relatively similar resident populations implies a possibility for policy lesson drawing between these provinces. All of these indicators are important measures of quality and safety, and each
is to some degree policy amenable. For example, provincial or regional policies and standards that enforce Health Canada’s existing warnings could help curtail inappropriate antipsychotic medication use, as has previously been done with physical restraint reduction in Ontario (Regional Geriatric Programs of Eastern Ontario n.d.). However, indicators that are multifactorial in nature and are not as directly policy amenable likely provide the greatest avenue for policy learning. Pain, for example, may be affected by a variety of factors, such as medication management and training of caregivers to recognize and treat pain more quickly. The ability to effectively deliver pain management interventions, however, may depend on inputs such as staffing level and compliment, as health care providers need both adequate time and knowledge of pain management strategies (Hadjistavropoulos and Hadjistavropoulos 2008). Thus, novel approaches and best practices that address complex problems of quality from a better performing province like Manitoba may be of specific interest to policymakers elsewhere.
Chapter 7: Conclusions and Policy Recommendations

Summary of Provincial Experiences

Lessons can be learned from each province’s experience with LTC policy reform since the 1990s. British Columbia’s radical reallocation of continuing care resources away from LTC and toward assisted living has resulted in substantial cost savings, seemingly without putting the province’s LTC quality out of step with Ontario, a substantially higher per capita spender. However, concerns have been raised about the effect this policy has had on access to LTC services, and the potential inequities this may create. The decrease in spending on LTC as a percentage of total health spending in BC is counterintuitive, given the rapidly province’s rapidly aging population. There is also the potential for BC’s policy stance to have unintended consequences elsewhere within the health system. It is curious that BC was the only province where spending on hospitals as a percentage of total health spending has returned to 1990 levels, and that this happened over the same time period as the disinvestment in LTC (see Figures 4.7 and 4.8). While many factors may contribute to this increase in hospital spending as a percentage of the total budget, it is logical to assume that increased ALC days as a result of availability of LTC beds has contributed to some degree. This question should be explored in future research, but answering it definitively would require access to comprehensive and accurate time-series data from across the health system.

Manitoba was the best performer in terms of the quality indicators, and also had the highest per capita spend on LTC of the 3 provinces. Although the quality data includes only facilities in the Winnipeg Regional Health Authority, this covers over 58% of the province’s population. Although recent data are not available, Manitoba has
historically been the highest spender of these three provinces on home care as well (CIHI 2007), and has a robust and comprehensive public system in place. The province’s commitment to aging in place has led to a small but growing investment in assisted living. The evidence from Manitoba shows clearly that although assisted living is important, it is not a panacea. In particular, assisted living cannot act as a direct substitute for LTC (Doupe et al. 2011). In terms of policy lesson-drawing, Manitoba’s stable financial support for continuing care over a number of years has likely resulted in these services being firmly entrenched in its provincial health system. The successful integration of these services seems to have led to improved continuity of care between the various continuing care options and other aspects of the health system, such as acute or primary care.

In Ontario, aging in place is also explicitly noted in recent policy documents, although continuing care issues have been viewed strongly through the lens of ALC, and the potential cost savings that can be achieved by caring for older adults in the community. This has created a perhaps overdue emphasis on respite or convalescent care, which can provide a much needed break for caregivers, and allow for the delivery of specialized rehabilitative care that can help some older adults regain the functional independence required to live safely at home. While there is an acknowledged need to increase LTC capacity in Ontario, LTC is not at the fore of continuing care policy documents. Concerns about the CCACs as effective purchasers of home care services have also been raised, and this may have effects in the future, as demand for private home care services grows. The long-standing involvement of the private sector in continuing
care in Ontario serves as an important policy lesson, especially given the clear preference many provincial governments have for market-based solutions in this sector.

**Limitations**

There are a number of limitations to this research. First, although the analysis leans heavily upon primary source grey literature such as government policy and planning documents, this literature only elucidates so much with regard to the intent and reasoning behind provincial policy decisions. As only documents that are in the public domain could be examined, it is possible that interpretation of these documents fails to account for critical information from behind the scenes. Key informant interviews could be used as another data source in future research to bolster the analysis of government documents.

The quality of the data used in Chapters 5 and 6 has already been discussed. Even if data were available publicly at the RHA level (which they currently are not), the cell sizes would preclude conducting robust multivariate analyses to answer specific questions, such as whether there is a relationship between provincial government spending and LTC quality. This sort of analysis may be possible in the future when the data coverage is improved nationally.

**Aging in Place Philosophy**

Whether implicit or explicit, the philosophy of aging in place is prevalent in the elder care system planning in all three provinces. As stated elsewhere in this paper, this is generally justified by stating that older adults prefer to receive care in their homes for as long as they are able, and indeed, the vast majority of older Canadians are never admitted to a residential care facility. Some older adults will choose to live at risk in the
community, and this population can be reasonably expected to grow as the population ages. Planning for the potentially increasing number of older adults living in the community by enhancing community supports, such as home care, is a prudent step, and one that governments will likely need to consider strongly if they wish to support aging in place.

However, what is sometimes glossed over by aging in place advocates is that provincial governments have already gone a considerable distance in implementing this approach. The decision to enter a LTC facility is one that is faced by a small percentage of Canadian families. This decision is intensely personal, and should involve a careful assessment of the individual’s needs, community supports available, and the availability of spouses, family members, friends, and neighbours to provide care and support. Given that less than 10% of Canadian older adults (CIHI 2011b) live in residential care settings, there is little evidence of institutionalization en masse.

Fundamentally, the rationale behind provincial governments adopting the language of aging in place is well-intentioned. It responds to the desires of seniors, and signals a move past paternalistic and ageist assumptions about what older adults can contribute to their communities. However, the shift towards aging in place has also been used as a vehicle to promote and expand lower intensity levels of care without concurrent investment in LTC. While they are less expensive for governments to provide, home care and assisted living options often involve a higher out of pocket pay component for users. More problematic still, they may be inadequate for older adults who are very frail, have advanced dementia, or who cannot be supported at home. Although the majority of older adults, when polled, may wish to receive care at home, relatively few have had the
experience of languishing at home with multiple chronic conditions, severe cognitive impairment, or other functional deficits that prevent them from effectively performing the activities of daily living. Absent a fundamental reimagining of what care in the community could look like (perhaps on the order of first dollar coverage for 24 hour care provided in the home), there will always be a percentage of the population for whom the goals of aging in place are nothing more than aspirational.

The dogmatic pursuit of the ideals of aging in place privileges the experiences of healthy, functionally independent older adults over those who require more complex care and is counterproductive to providing the most appropriate care to some of our most vulnerable citizens. Fisher (2014) describes aging in place as an option that “works until it doesn’t”; while frail older adults may be able to remain in their homes for longer than they currently do, many will eventually encounter a change of circumstances that challenges this ability. LTC provides a vital safety net for older adults and their families, and in the face of unprecedented population aging, it cannot be downsized without consequences being felt elsewhere in the health system.

**Policy Recommendations**

The political feasibility of various policy alternatives for the continuing care sector has been discussed in detail in Chapter 3 of this document. If the overarching policy goal is to reduce government spending on LTC, then the policy experiment in British Columbia provides an obvious example of how this may be achieved. However, given that other governments have not yet followed B.C.’s lead, it can reasonably be assumed that other provincial leaders have not seen this as a clear and obvious road to cost containment. Indeed, the policy goal should be to create a durable and flexible
system of elder care to deal with the needs of an aging population, one that both recognizes older adults’ need for independence and autonomy and acknowledges that, for some, the best care options do not lie in the community. A more flexible continuing care system can help older adults and their families navigate the health care system and access the supportive services they need before they reach a health crisis and require the most costly care option of all for the public health care system: an extended stay in an acute care facility.

Given the existing evidence already discussed in this document, the following three recommendations are keys to building the continuing care system required to meet the needs of the aging population.

1. *Invest in a robust continuum of care*

   As introduced in Chapter 1, continuing care exists on a continuum from the least (informal and formal home care) to the most (LTC) resource-intensive care. While it may be tempting for policymakers, who must balance a number of health system priorities, to focus efforts on just one care setting, investing in only one part of the continuum is not a panacea. Jones (2007) writes:

   “…there is an inherent contradiction when expansion on the continuum of care abandons one form of care for another. One housing choice cannot substitute for another. Long-term care beds provide medical necessities for people with complex care requirements. Assisted living buildings cannot provide this level of care and are characterized by a comparably low level of supervision and assistance.” (41)

   This can be argued to be the most important policy learning from B.C.’s aggressive move towards assisted living. The loss of LTC beds in B.C. has created pressures elsewhere in the health system, as the substitution effect of assisted living has been less than expected (Jones 2007).
All existing evidence suggests that more LTC beds will be required to meet the demand created by population aging, and governments should act on this evidence before we have reached the peak of the demographic shift. However, while home care and assisted living cannot act as direct substitutes for LTC, they are key parts of the continuing care continuum which also should be maintained. Home care plays a vital role in providing short-term supportive care for clients and their families, at lower cost than in a facility setting. Assisted living can be a positive housing option for older adults who are unable to stay in their own homes for health or social reasons but who are relatively self-sufficient in their activities of daily living.

Other community programs, which complement the continuum of care, also provide vital supports for older adults and their families. Ontario’s recognition of the importance of short-term respite or convalescent care is one such example of a community care program that can facilitate clients getting rehabilitative care, as well as provide an often much-needed break for informal carers. Adult day programs, which are in place in most Canadian jurisdictions but are relatively small in scale, can allow older adults to maintain social connections within the community while providing respite to caregivers. Programs like these help reduce caregiver burnout, and funding for these programs cannot be lost in the shuffle in a policy environment where aging in place is emphasized.

Doupe (2013) stated in a recent presentation about LTC bed projections in Manitoba that it is difficult to imagine the demographic shift unfolding without governments needing to supply “more of something” in the way of continuing care. While it is clear that the status quo is not an option, it is likely that supplying more of just
one thing (i.e. LTC, home care, or assisted living) will not be sufficient or cost-effective. A renewed commitment to a robust continuum of care that includes adequate LTC spaces is required.

2. Pay detailed attention to care transitions

Older adults who require care often transition between a number of care settings during their lives, including emergency departments, inpatient acute care, home care, and LTC. Each of these transitions presents an opportunity for information sharing and care coordination, but the degree to which this happens in a fragmented system where primary, acute, and continuing care systems often do not interface is unknown. There is a great need for these systems to be better integrated, and for shared information technology tools, such as electronic medical records, that follow older adults across care settings.

Care transitions often also represent a significant change in the care required by an older adult. An ED visit or a hospital admission can be a result of the fact that the client or their carers are struggling at home. Rationing access to services until a crisis, as is currently the norm in continuing care, is unlikely to be cost-effective or efficient (Beattie 2014). Better system integration would help clients and their families navigate the system, and potentially access an appropriate level of care before a crisis is reached. One example of how this recommendation can be operationalized is Ontario’s Health Links model, a funding model that allows for local innovation in creating integrated care approaches that utilize family health teams. Health Links will ideally allow local groups to identify barriers in the health care system that affect care for seniors and other high users of the health care system (Silversides and Laupacis 2013).
3. Consider the culture and design of LTC

That public perceptions of LTC are often negative should not come as a surprise. These perceptions are likely rooted in our fears about the possibility of losing functional autonomy as we age, and reinforced by media horror stories about care that is not person-centred (e.g. “Ontario’s casual approach to drugging seniors with antipsychotics”, Toronto Star, April 22, 2014), or, in rare but high profile cases, negligent or abusive (e.g. “Patient in long-term care has face nibbled by mice”, Calgary Sun, September 9, 2013). Facilities are often viewed as sad places, cold and institutional warehouses for the infirm. Because LTC is a viable and important care option a certain segment of the older adult, there is a moral imperative to improve both the care environment and the care provided.

A number of innovations in this sector are currently being experimented with. The built environment in LTC has been the subject of much recent research interest, with a simple question in mind: How can LTC facilities look and feel less like smaller hospitals and more like homes? One example that has garnered a great deal of media attention in recent months is a “dementia village” in Holland. The “dementia village” is a care facility that functions as a self-contained village for residents with dementia, complete with a restaurant, grocery store, cinema, and hair salon. Residents are allowed to move freely within the facility even while all areas are staffed by care providers. There is no way residents can accidentally wander off the premises because the village is entirely self-contained (CNN 2013). In Canada, village models for LTC have also been introduced, most notably the Schlegel Villages in Southern Ontario (Hammond 2011).

In terms of care itself, a variety of care philosophies are also challenging our perceptions about continuing care. One example is the Eden Alternative philosophy,
which has been adopted in a number of Canadian jurisdictions. The Eden Alternative rejects ageist assumptions, and treats older adults and their carers as care partners, each an active participant in the care process. It is person centred and focuses on relationships rather than processes (Eden Alternative 2014).

**Future Research Directions**

Although this study has speculated about the outcomes of the policy directions in each province with regard to access to LTC, there is little empirical evidence about access. This likely stems from the difficulty of obtaining accurate information about the total number of LTC beds in each province and the wait times faced by clients for these beds. Also, little is known about entirely-private LTC facilities that receive only unsubsidized clients with the ability to pay, making it difficult to understand the full scale of this part of the LTC sector. Future research should examine the trends over time in LTC beds per capita for those over the ages of 65, 75, and 85, the average wait time for a LTC bed, and the exact number of parallel private LTC spaces in each province in order to gain a more complete picture of the impact of policy choices on access.

Another issue raised by this thesis that should be examined in future research is the extent to which ALC as a result of longer wait times for LTC beds resulted in the rise of hospital spending in British Columbia after the Continuing Care Renewal was initiated. To do this, a variety of confounding variables would need to be controlled for, including the increase in remuneration for hospital staff and the increase in utilization across age groups. If indeed there is a correlation between disinvestment in LTC and rising ALC (and thus hospital) costs in British Columbia, this would have substantial policy implications.
Conclusions

The evidence from Chapters 4 and 5 of this thesis suggests two things: one, that it is possible to “bend the cost curve” in LTC, and two, that there is a relationship between per capita provincial government funding for LTC and LTC quality. The fundamental underlying question, however, is whether continuing care is predominantly the responsibility of the state, or of the individual. Recent policy choices in Canada have been largely based on the acceptance of some degree of personal responsibility for continuing care, as evidenced by the growing out-of-pocket expenditures on LTC and growth of the entirely private second tier of care facilities that exclusively serve unsubsidized clients. Even programs such as Quebec’s proposed Assurance-Autonomie, which expand the role of the state in the provision of continuing care, require contributions from individuals in the form of premiums rather than being financed solely through taxation.

While some have called for LTC, along with home care and assisted living, to be included in the basket of Medicare services under the Canada Health Act (Jansen 2011), there is little political will for this change given the current economic climate. However, even in the current climate of fiscal restraint, population aging will necessitate investments in continuing care and social services. As previously noted, a robust continuing care continuum will be required to meet the needs of the aging population. This will require investment to varying degrees in home care, assisted living, and LTC. The important role that informal carers play also cannot be overlooked, and further policy must be developed to support them both financially and with their health and social needs. As older adults are institutionalized closer to end-of-life, palliative care, which is
often the domain of hospitals or specialized hospices, will need to be provided in LTC as well as in the home.

Future planning for LTC must focus on increasing access, as long waits lists create costly pressures elsewhere in the system and place undue stress on families and caregivers. Equity is also important. While subsidies exist for clients of lower socioeconomic status, these clients also inarguably pay a higher percentage of their often limited incomes toward their care, making LTC fees the equivalent of a regressive tax on those who require care. These clients are sometimes also forced to dip into their savings, or leverage their home equity in order to pay for necessary care, a situation many Canadians would find outrageous if they were forced to do the same for hospital or physician services.

In the future, policymakers should also focus on LTC quality. This may include research into under-examined issues such as the relationship between staffing levels and mix and quality of care. It should also include a renewed commitment to the systematic collection and analysis of quality of care data, as is currently done through CIHI’s growing Continuing Care Reporting Service, and through governmental bodies such as Health Quality Ontario. These data are vital to understanding the LTC resident population, their care needs, and whether or not these needs are being met. The resident experience is also important, and existing patient satisfaction tools could be leveraged to learn more about the world of LTC from the perspective of clients and their families.

Most importantly, though, is to understand that there is no single policy solution. Our growing older adult population is not homogenous, and is comprised of people with a wide variety of needs, desires, and values. A one-size-fits-all approach will not work.
While LTC can and should look differently in the years to come, it is an option that needs to be available to frail seniors. Governments recognizing this need and adequately responding would be a crucial first step in building a continuing care system where no one falls through the cracks.
References


Canadian Institute for Health Information (CIHI). 2013b. Report on Canadian Residential Care Facility Rates (Draft). Ottawa, ON: Canadian Institute for Health Information.

Canadian Institute for Health Information (CIHI). 2013c. When a nursing home is home: How do Canadian nursing homes measure up on quality? Ottawa, ON: Canadian Institute for Health Information.


Canadian Institute for Health Information (CIHI). 2013e. The Why, the What and the How of Activity-Based Funding in Canada: A Resource for Health System Funders and Hospital Managers. Ottawa, ON: Canadian Institute for Health Information.

Canadian Institute for Health Information (CIHI). 2013f. Continuing Care Reporting System Risk Adjustment Methodology. Ottawa, ON: Canadian Institute for Health Information.
Canadian Institute for Health Information (CIHI). 2012. *Seniors and Alternate Level of Care: Building on our knowledge*. Ottawa, ON: Canadian Institute for Health Information.


Canadian Institute for Health Information (CIHI). 2009. *Analysis in Brief: Alternate Level of Care in Canada*. Ottawa, ON: Canadian Institute for Health Information.


http://www.communitybasedresearch.ca/Page/View/Deinstitutionalization.html


http://www.healthpromotionagency.org.uk/Healthpromotion/Health/section6a.htm


McGrail, Kimberlyn. 2011. “Curing our Boomerangst: Myths and realities of and possible responses to the demographics and macroeconomics of an aging population.” Keynote address at Canadian Association on Gerontology Annual Scientific and Educational Meeting, Ottawa, Ontario, October 22.


Retrieved from:

http://www.releases.gov.nl.ca/releases/2014/health/0304n01.htm


http://www.lhins.on.ca/legislation.aspx


Toronto: Office of the Auditor General.


Special Senate Committee on Aging. 2009. *Canada’s aging population: Seizing the opportunity.* Ottawa, ON: Senate of Canada.


Winnipeg Regional Health Authority. “About Us.” http://www.wrha.mb.ca/about/aboutus.php

