Seniors for Social Action Ontario

COMMENTARY ON THE FRASER INSTITUTE REPORT RETHINKING LONG-TERM CARE IN CANADA BY YANICK LABRIE

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Covid 19 exposed Canada's facility-based Long Term Care (LTC) system as failing vulnerable seniors in the most tragic of ways with 14,739 deaths by February 2021, more than two-thirds of all Covid-related deaths in Canada.[1] Calls for "transformation" have centred on improving living conditions and levels of care in nursing homes, introducing "emotion-based" care approaches, expanding "bed" capacity in new more modern facilities, and setting national standards and accountability mechanisms for facility operators. The higher infection rates and death toll in homes operated by for-profit companies compared to non-profit and public providers are raising calls for the removal of profit-making care from the system.

The focus of transformational thinking on improving the institutional LTC system overlooks the fundamental flaw in the facility-based approach when it comes to the protection and care of vulnerable seniors, i.e. a congregative service model highly susceptible to the spread of viral infection. And, Covid or any viral pandemic aside, after a productive life as citizens, it is unnatural and inhumane for seniors requiring healthcare and living supports to spend their last years in large institutions, segregated and excluded from their natural environments - family, friends, neighbors, and community. Nine out of ten Canadians do not wish to leave their community for nursing homes at the end of life.

Although concerns about the nursing home situation arise periodically and then recede with political rhetoric promising reform and allocating more funding to the existing system, the pandemic exposed fundamental flaws in the predominating institutional model of LTC. One-quarter of residents (22,000) died annually in LTC facilities prior to the pandemic. The Ontario Covid-19 Long-Term Care Commission heard testimony that "the average age of long-term care residents . . . is 84" and that "residents typically enter a long-term care home in the last two years of their life." As this author has asked in another publication, "one wonders why society cannot manage its resources so that [staying in home/community] could happen for all to the end of life. Why concede that the last few years should unfold for so many in an environment as foreign to home, family and community as imaginable?"

Home- and community-based models that facilitate aging in place and community living for other age groups are aplenty. Yet, the discussion in Canada gives secondary, even incidental, consideration to this model of senior care. It is in this context that it useful to look at other national jurisdictions in comparison to the Canadian LTC experience. This is done by Yanick Labrie in his *Re-thinking Long-Term Care in Canada. Lessons on Public-Private Collaboration from Four Countries with Universal Health Care*, released by the Fraser Institute in October 2021.

Reviewing the LTC systems in Germany, Japan, The Netherlands and Sweden, Labrie draws some sharp contrasts with the Canadian system in terms of both institutional and community-based care and in the roles of the for-profit, non-profit and public sectors. Not unexpectedly as a Fraser Institute publication, Labrie's analysis and conclusions reinforce the role of the private, profit-making sector,

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[1] Although this review does not report the proportion of LTC deaths from Covid in the four countries being compared with Canada, other research indicates much lower percentages than Canada's for three of them: Germany (30%), Sweden (47%), The Netherlands (51%).

especially in the clear shift to community-based services. While the Canadian debate tends to centre on whether to remove profit from the facility-based system, Labrie argues that the profit-making approach is performing "successfully" in the four countries in his comparative study, not only in institutional care but also in expansion into the home- and community-care market as well. The key issue is the measures of success that are used.

Overview Comparison with Canada

Labrie reports that Canada allocates 2% of GDP to LTC expenditures, the same as Japan, but lower than Germany (2.2%), The Netherlands and Sweden (both 2.9%) while having a smaller seniors population than these countries.[2] Canada (3.8%), again except for Japan (3.6%), has a lower proportion of residents in LTC institutions, compared to Germany and Sweden (each 4.2%) and The Netherlands (4.4%). Labrie does not offer the breakdown of GDP allocations between institutional and home care for the four countries in the study.

Labrie explains that the main difference between the Canadian LTC model and its four OECD counterparts is that they each have integrated eldercare into their universal healthcare insurance programs, allowing access to services based on age and specific healthcare needs, while in Canada LTC at the provincial level is based on needs assessments and means testing funded primarily through federal transfers. Governance of LTC in all five countries is decentralized, but that decentralization in Canada is at the provincial or regional level, while in the four comparator countries it has devolved to the municipal level.

LTC is publicly funded at 91% to 93% in Japan, The Netherlands and Sweden; only Japan (72.1%) has a lower level of public funding than Canada (78.4%). Canada (18.3%) and Germany (23.8%) have much higher levels of financial contributions (co-payments) by seniors for their healthcare needs than Japan (8.2%), The Netherlands (6.7%), and Sweden (6.9%). All four countries make provision for cost coverage or subsidy support for lower income seniors that cannot afford to make the financial contributions. Importantly, LTC funding supports the healthcare requirements of seniors, not accommodation and food. So, LTC is integrated into universal health coverage in these countries but that does not necessarily mean that Seniors' healthcare is integrated into other required forms of social care and support that ensure overall well-being.

Labrie shows that institutional care in Canada is much more balanced across the public (46%), not-for-profit (23%) and for-profit (29%) sectors than the four countries in his review. Not-for-profit institutional care holds the highest share in Germany (53%), Japan (79.1%) and The Netherlands (87.8%). Non-profit institutional care in Sweden is miniscule (1%), while public sector provision (79.9%) prevails and the for-profit sector expanding in more recent years to 19.2%. Compared to Japan (13.9%) and The Netherlands (12.2%), Germany (43%) shows the highest share of for -profit institutional care. Labrie points out, however, that for profit companies in all these countries are expanding into the community service market with the support of public policy and resources.

Labrie's Analysis

In sharp contrast to the Canadian scene, Labrie cites studies in all the comparator countries that indicate the for-profit sector outperforms the non-profit sector in terms of both cost efficiencies and

[2] A Queen's University study by economists in November 2020 actually shows Canada's share of GDP to LTC as only 1.3%, commenting further, "Worse still, measly 0.2 per cent of GDP Canada spends on home care is one of the lowest allocations to home care in the OECD." (p.4)

service quality, although the exact metrics would require closer investigation of the sources offered. Labrie firmly concludes that the competitive, market-based approach has opened the field in the last decade or more to private-public partnerships to meet the demands of increasingly aging populations.

Further, Labrie asserts that seniors in Germany and The Netherlands value the choice afforded them through "cash benefit programs" to arrange and shape their own care. Sweden also allows cash payments for community care for seniors requiring at least 17 hours a week of care. Japan has no cash benefit program, but individuals may choose institutional or home care with limits depending on the level of care required. Provided primarily by the for-profit sector, Japanese may top up their home care service through private insurance or other personal resources.

The cash benefit programs in Sweden, The Netherlands and Germany vary to some degree but they are based on the same principle – seniors and their families can choose to access cash transfers for their care in lieu of nursing home placement. In the last 20-30 years, these governments have found this approach is less costly for universal coverage than facility-based care. Combined with decentralization of eldercare management to the municipal level, the delivery of healthcare is seen to be more responsive to both individual and local needs. Labrie cites studies in the comparator countries that indicate the for-profit sector has been more nimble than the non-profit sector in adapting to this model, especially in terms of shifting to home-based and community-based care. For profit providers are better positioned to compete for municipal contracts and are more creative and innovative in developing more "personalized" approaches that, in reference to The Netherlands, "reconcile[es] the logic of the market with the logic of care."

Labrie draws the following lessons for Canada from the LTC systems in these four OECD counterparts:

1. Universal access is not being denied by "non-negligible" contributions by elder "patients" to their own healthcare; provision is made to cover the needs of seniors with low incomes.
2. The market approach of consumer choice and competition among a diversity of providers produces both cost efficiencies and good service quality in the four LTC systems.
3. The increasing shift to home care from institutional care in all four countries is both preferred by seniors who wish to stay in their communities and supported by governments for its cost savings on eldercare compared to institutional care.
4. Decentralization is the first step to the shift to community care since it brings decision-making on the eldercare system to the municipal level where local needs are better understood.

Commentary

For-Profit Domination of Eldercare. Probably the most striking contrast with LTC in Canada is the validation if not encouragement of a much stronger role for the for-profit sector in eldercare in the four countries under study. The Canadian for-profit LTC sector has come under particular criticism in recent months for the higher Covid infection and death rates in its facilities compared to non-profit and municipally run facilities. But, the idea of profit-making in LTC and in human services in general has been questioned previously for decades.[3] Suggesting this thinking is ideologically driven, Labrie touts the market competition model in these four countries as the driving force not only in facility based LTC service but also in the major shift to home and community-based eldercare. He characterizes the

[3] The Social Planning Council of Metro Toronto produced *Caring for Profit. The Commercialization of Human Services in Ontario* as early as 1984 and an updated report on the worsening situation in 1997 called *Merchants of Care? The Non-Profit Sector in a Competitive Social Services Market*; The Canadian Centre for Policy Alternatives produce a landmark report on Caring for Profit in 1998.

non-profit sector in these countries as a lagging player in the "industry", slow to adapt to the aging demographics, and increasingly relegated to more traditional institutional care delivery.

Clearly, when governments adopt universal access to a service area, like healthcare and LTC in these countries, especially in a demographic like aging, the scale of the available market becomes a very attractive source of revenue and profits to private enterprise. Labrie says that universality in LTC "has ushered in a new era of eldercare entrepreneurship" in these four nations. Introducing competition among multiple for-profit operators would generate innovation and creativity to satisfy both governments' need for savings and "consumer" demand *and* preferences in services. Some of this innovation may be questionable in terms of appropriate care, such as the focus in Japan on robotics to provide service to seniors instead of paid staff or supporting other family/community personal relationships.

But also, the diversity of competition in the early stages of any expanding market opportunity can over time consolidate into fewer larger players, becoming an oligopolistic market where the providers have more control over price and choice. Entrepreneurial single proprietorships and partnerships can evolve into shareholding corporations where profit-seeking prevails over care. The Canadian for-profit institutional sector in LTC reflects a more mature market in that regard. Perhaps, it is too early to say where the for-profit sector and possibly more limited competition in LTC will lead in these four comparator countries.

It is clear in Canada, however, that the Covid pandemic exposed huge disparities between the for-profit and the non-profit/public LTC sectors on the most critical measures of safety and healthcare, infection rates and deaths of residents. There are many examples in Ontario of the government mandating hospitals to assume management control of for-profit operations to navigate through the pandemic. In September 2020, the Ottawa Hospital assumed management responsibility for two nursing homes run by the for-profit corporation Extendicare; the North York General Hospital was asked by the Ontario Government to take over the Tender Care Living Centre in Scarborough in December 2020; the Ontario Government also engaged the Red Cross Society to assist in a number of LTC nursing homes in the Ottawa Region under the ownership of Revera, Sienna Living and Extendicare, all for-profit providers. More recently in October 2021, the Saskatchewan Health Authority is taking over five Extendicare homes in the province.

The issue of caring for profit is important, and is worrying if it is the driving force for "transformation" in the four subject countries as Labrie contends is happening with a wave of entrepreneurial energy reflected in multiple contract bidders. As the market consolidates and the players with the lowest bids prevail, will the performance outcomes Labrie suggests continue. Whether the competitive market process engages both for-profit and non-profit operators, however, when it comes to bidding for institutional "beds", the outcomes are heavily weighted more towards cost controls and efficiencies than resident care and active participation in family and community to end of life.

Prospect of Multi-Tiered Systems. Labrie asserts that integration of LTC into each country's universal healthcare system with full or subsidized coverage of "patient" co-payments for those with incomes below a certain threshold ensures the key principle of universality, i.e. access to needed services. In addition to equitable access, however, there remains the issue of equity in terms of type and quality of service received. This may play out differently in each country. In Germany, the health insurance including for LTC is mandatory and the public scheme covers 89% of the population. A vibrant private insurance industry covers the remaining 11%, but its existence suggests inequity in service by income and wealth.

Even with insurance, co-payments in Germany are high at 24%. One wonders how manageable this is for low income seniors and Labrie does note that "as in other European countries home care services in Germany have been shown to be disproportionately concentrated among the poorest seniors." A means-tested social assistance program does provide some relief to the poorest senior citizens. Labrie points out that the for-profit sector in Germany has grown significantly in the last 20 years in both the institutional and community service markets.

In both Japan and The Netherlands the for-profit sector has dominated in the shift to home and community eldercare, while the non-profit sector has been fairly concentrated in institutional care. With the highest proportion of seniors in institutional care (4.4%) among the four countries, The Netherlands has aggressively shifted to home- and community-based care, phasing out independent living units for seniors with low assistance needs while a person-centred "well-being approach" was employed to arrange service packages and small scale community homes. Still, the institutional option seems to prevail for seniors requiring more intensive care. For-profit operators have also expanded their share of institutional care in recent years offering a diverse range of facilities: "while some providers aimed explicitly at delivering care to more affluent seniors, others target elderly people belonging to low- and middle-income groups, or those suffering from cognitive impairments or dementia." Thus, in a competitive for profit system, market segmentation can mean differentiated service offerings based on personal means.

The Promise and the Cautions of Cash Benefit Programs. One of the key ways that the market approach is being adopted in Germany, The Netherlands and Sweden is the choice for seniors to opt for a cash benefit for their home care as an alternative to institutional care. Since the costs of cash benefit programs are less expensive than institutional care, there are financial savings to the municipalities administering LTC. Labrie reports that for-profit providers are leading in developing the home and community care market in these countries.

Although there are financial limits on the cash benefit programs and some conditions on the kind and level of care (e.g. Sweden's eligibility requirement of a minimum 17 hours of care weekly for cash payment), the introduction of choice between home/community care and institutional care is very appealing to seniors and their families. This is encouraging to Canadian advocates for person-centred planning and direct funding that enable persons with disabilities to live in community. They have promoted this personalized model, however, not just for persons with mild or moderate physical or developmental limitations, but for everyone with extraordinary needs so that the institutional option is phased out over time.

Senior-led groups such as Seniors for Social Action in Ontario (SSAO) advocate for models that tie funding to the individual requiring support so that they can arrange the services appropriate to their particular needs. This kind of cash transfer amounts to a market approach and requires several important safeguards: first, setting up an independent non-profit brokerage and coordination function to assist the individual to create an appropriate array of services; secondly, ensuring service providers, both for profit and non-profit, are registered as qualified to deliver a high standard of care; thirdly, recognition that an individual's needs change over time so that flexibility in funding levels adjust accordingly. The example of the joint public authority set up in Norrtälje in Sweden described below reflects this kind of oversight and protection.

While the cash benefit programs in Labrie's review are an encouraging development, institutional care still prevails in the countries under study and most of the growth in this part of the market is also being carried by the for-profit sector. In the 20 years up to 2019, Labrie says that LTC facilities in Germany increased from 8,333 to 14,494; in The Netherlands more than half the 274 for-profit LTC providers

entered the market between 2016 and 2019. For-profit providers grew their share of the LTC facility market from 1% in 1990 to 19% in 2020, although the shift to home and community care reduced by a third seniors living in nursing homes. Japan, lacking a cash benefit program but supporting the shift to home and community care still had growth in LTC facilities from 500 in 2000 to 13,499 in 2017.

So, while it is encouraging that three countries in the review offer cash transfers for more personalized service packages, it is clear that cost control and market competition are the main drivers of this shift. Although Labrie reports that recent studies in these countries indicate that current practice is performing well and there is high senior satisfaction with this approach, the inclination of the market to cut costs and increase profits over time bears close vigilance as it evolves. Labrie's assessment that the non-profit sector is not as active or innovative on the home and community care front does give pause, since the community service mission of the non-profit sector could provide some counterweight to the dynamics of cost control and profit generation.

Labrie acknowledges that decentralization and user choice within a competitive market can create fragmentation within the healthcare system. But, he points to the Swedish example of how many municipalities have developed coordinated care models that facilitate user choice with appropriate protections. He offers the example of Norrtälje, a large Swedish municipality in Stockholm County. In 2006 a financial crisis threatening the closure of the local hospital brought together concerned stakeholders to create a new joint public authority to oversee the home and community-based care for seniors, accrediting both public and private providers to adhere to defined principles of practice and specific performance standards.

At the individual level models such as Norrtälje's provide a level of user protection against questionable market providers but they also allow the oversight bodies to collect data on community needs and gaps that the system can then plan to fill.

Limits of Decentralization. Labrie very explicitly grounds the basis of what he judges to be the success of the reforms in the four countries in the decentralization to municipalities of planning and management of the LTC systems. Most often referred to here in Canada as the principle of subsidiarity, it is generally acknowledged that public decision-making is best done at the level closest to the people who will be the most affected. The challenge particularly in federated systems like Canada with provincial authorities governing mostly large geographic territories is how to ensure equitable services across provinces and communities. This is Canada's historic dilemma in defining and enforcing national standards in healthcare and now Long Term Care. Provinces wish and need access to the federal tax base to fulfill their constitutional mandate to deliver health services but they generally resist federal conditions for the transfer of funds.

The question for LTC advocates is whether strong, national standards should be established in universal eldercare. If so, should they be minimal or expected standards of care? How much flexibility should there be in how those standards are met provincially and locally? If resources were allocated to municipalities in Canada for eldercare systems, how would communities be engaged in their design and implementation?

But there is another major consideration with respect to decentralization. Labrie suggests that the national governments in these four OECD countries saw decentralization as necessary to develop and deliver services based on local needs but they were also very definitely motivated by the need for cost control and savings. In his account, the municipalities negotiate contracts increasingly more with for-profit providers on a competitive bid basis. While Labrie asserts that these offers include service performance expectations, it is clear that cost control is a major determinant in successful bids.

Decentralizing to the municipal level for service delivery brings with it financial constraints. The Canadian experience with decentralization in the 1990s was driven almost entirely by the deficit and debt control strategies of senior governments. Off-loading and downloading responsibilities and services without the accompanying transfer of resources required to meet them became the order of the day. Devolution and downloading are not the same as authentic decentralization. It is unclear whether municipalities in the four countries in the review have felt this kind of financial pressure in their assumption of the oversight role for LTC in their areas.

While getting service design and delivery closer to local communities is an admirable objective, it is important to measure the opportunity for local control against the importance of ensuring cross-community solidarity on expected levels of care and the provision of the necessary resources to create locally responsive support systems.

Conclusion

Labrie's review indicates major shortcomings in the prevailing model of LTC in Canada compared to the four countries that he covers. Yet, his suggested "re-thinking" of the system in Canada for comparable "success" by emphasizing a competitive market approach to transforming LTC is highly questionable. Success in the market model focuses primarily on controlling costs in the response to ageing demographics in all of these national populations. The shift to home and community care does respond to seniors' wishes to stay in their home communities, but is mostly attractive to government funders because of favourable cost comparisons with institutional care.

Integration of LTC into the national universal health programs does provide some security on healthcare but in several countries personal means enable some seniors to enhance their care with supplemental insurance and seniors on the lowest incomes, although not denied access to healthcare, may not have the personal means to provide for their other social care needs, making them higher risk for healthcare through institutional placement. While for-profit providers may be the leading players in the home and community care market for seniors, they are also growing their presence in institutional care. Markets and public finances, profits and costs are the primary drivers of the re-thinking occurring in these nations.

If there is a legitimate role for profit-making in LTC reform, which as stated above is strongly contested ground in Canada, it should be highly regulated and, most importantly, situated within an explicit public commitment to seriously transform the health and social care of seniors to a home and community care model, phasing out institutional care over a defined period of time. The path to true success in transforming LTC lies in that direction not only in Canada but internationally as well.

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