THE NACA POSITION ON THE PRIVATIZATION OF HEALTH CARE

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National Advisory Council on Aging

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The Division of Aging and Seniors provides operational support to the National Advisory Council on Aging.

THE NACA POSITION ON... is a series of policy papers presenting NACA's opinions and recommendations on the needs and concerns of seniors and issues related to the aging of the population.

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WHAT IS THE NATIONAL ADVISORY COUNCIL ON AGING?

The National Advisory Council on Aging (NACA) was created by Order-in-Council on May 1, 1980 to assist and advise the Minister of Health on issues related to the aging of the Canadian population and the quality of life of seniors. NACA reviews the needs and problems of seniors and recommends remedial action, liaises with other groups interested in aging, encourages public discussion and publishes and disseminates information on aging.

The Council has a maximum of 18 members from all parts of Canada. Members are appointed by Order-in-Council for two- or three-year terms and are selected for their expertise and interest in aging. They bring to Council a variety of experiences, concerns and aptitudes.

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NACA BELIEFS

NACA believes that:

- Canada must guarantee the same rights and privileges to all its citizens, regardless of their age.

- Seniors have the right to be autonomous while benefitting from interdependence and to make their own decisions even if it means ‘living at risk’.

- Seniors must be involved in the development of policies and programs and these policies and programs must take into account their individuality and cultural diversity.

- Seniors must be assured of adequate income protection, universal access to health care, and the availability of a range of programs and services in all regions of Canada that support their autonomy.

In Canada, health care financing, allocation, and delivery may be public, private, or a combination of both.

The important question is not whether something is public or private, but rather how the arrangement of public or private financing, allocation, and delivery affects costs of care, access to care, accountability for care, and quality of care.

The National Advisory Council on Aging (NACA) believes that health care should be available to all on the basis of need rather than ability to pay, that providers of health care are accountable to the public for the services they provide, and that the criteria for evaluating health care must include quality and equity, as well as effectiveness and efficiency.

In this report, NACA identifies what mix of public and private should be maintained in the Canadian health care system, if that system is to continue to offer universal access to quality care for Canada's seniors.

In particular, NACA recommends that:

- Medically necessary health services continue to be entirely publicly funded through a"single-payer" system at the provincial/territorial level.

- Publicly funded services be expanded to comprise all medically necessary services, including home care, prescription drugs and health technologies. The definition of medically necessary services should take the global health needs of seniors into account, including personal care and homemaking needs.

- In expanding the coverage of medically necessary health services provided by a "single payer" system, provincial and territorial governments consider the positive effects of public funding in controlling total health care costs and in reducing the potentially disproportionate burden of the private costs of care on seniors and their informal caregivers.

- Provincial/territorial governments ensure that senior consumers be fully represented in local health decision-making and planning.

- Provinces and territories provide a core package of services that covers the continuum of care in all regions, establish province-wide standards and protocols and monitor compliance to these standards and protocols.

- Single-entry models of access to all services be made available in every community, to assure that seniors have access to the full continuum of care.

- Provincial/territorial governments allocate the funding required to meet the needs of each region for community-based services.

- Provincial governments and regional health boards involve the community care sector as a full and equal partner in all health care decision-making and planning.

- The federal government set national standards governing accessibility and the provision of a core package of services for the transfer of funds to the provinces/territories for social and health-related services.

- Provincial and territorial ministries of health monitor and evaluate trends in out-of-pocket charges for long-term or hospital accommodation.

- Provincial and territorial ministries of health develop a payment schedule for long-term care or hospital accommodation that ensures fair and affordable access for all residents and that does not penalize individuals for gaps in the continuum of care, such as inadequacies in discharge planning or in long-term care places.

- Federal, provincial and territorial ministries of health collaborate in developing criteria for decisions to de-insure health services and monitoring the impact of those decisions. The criteria should include the effects on health, quality of life, potential illness, equity of and access to health care, and total (public and private) health care costs.

- Provincial and territorial governments take a major role in the public regulation of home care services, the management of competitive contracting processes and the management of monitoring and accountability processes, in order to ensure quality of care, equitable access to care, and timeliness of services.

- Provincial and territorial governments develop standards and evaluate services for home care that involve seniors and their informal caregivers, as well as professional care providers and agency administrators, to ensure that effects on quality of life are taken into account along with effects on health status.

- Provincial and territorial governments develop indicators pertaining to the relative allocation of resources to client services, staff remuneration, staff accreditation, and staff training and support to assess quality of care and to award contracts for home care services.

- Provincial and territorial governments provide sufficient resources for home care to ensure adequate remuneration and appropriate training of paid caregivers, and to avoid shifting the burden of home care to low-paid workers or unpaid caregivers, most of whom are women.

THE NACA POSITION ON THE PRIVATIZATION OF HEALTH CARE

INTRODUCTION

Universal access to health care based on need rather than ability to pay is a fundamental value of Canadian society. Canadians are proud that in Canada there is a "single-tier" health care system, with one point of access for everyone irrespective of ability to pay.

In the minds of many, privatization of health care means an American system of health care — a "two-tier" system that offers better services for those who can pay and poorer or no services for those who cannot.[1] But what, exactly, is "privatization?" It depends on which of the three major dimensions of health care one is considering — financing, allocation, or delivery. Privatizing the **financing** of health services means shifting the burden of paying for health care from the tax revenues of governments to the private incomes of individuals through user fees, partial or complete payment for certain services, and private insurance. Privatizing the **allocation** of health services involves using certain forms of market competition to determine what services are provided, who provides them, and what they cost. Privatizing the **delivery** of health services means relying on individuals and organizations outside of government — both non-profit and for-profit — to provide the services.

In Canada, each of these dimensions of health care — financing, allocation, and delivery — may be public, private, or a combination of both.[2] For example, medically necessary hospital services are completely publicly financed, whereas dental care is largely privately financed through either private insurance or out-of-pocket expenditures. Similarly, the allocation of health services can be regionally planned, as when regional

health councils make decisions about closing hospitals, or can follow more of a market system, as when individuals chose their personal physician. Likewise, the delivery of some health services — public health programs, for example — is entirely public, the delivery of others — hospital services or long-term care, for instance — is a combination of public and private, and the delivery of many services — for example, those of a physician or a pharmacist — is entirely private.

Privatization in health care is not necessarily objectionable in and of itself. In fact, there are good arguments in favour of the private delivery of certain kinds of health services. At the same time, however, there are very strong arguments in support of the public financing of health care. And there are concerns about how changes in health care are altering the balance of public and private allocation of health services. **The important question is not whether something is public or private, but rather how the arrangement of public or private financing, allocation, and delivery affects costs of care, access to care, accountability for care, and quality of care.**

The private/public balance in health care is particularly of concern to seniors, because they are more likely to need health care than other Canadians,[3] and because they have lower incomes.[4] Seniors are more likely to have chronic illness, activity limitations, and physical disability.[5] They account for a greater percentage of stays in hospital or use of prescription drugs than other age groups.[6] Although the incidence of low income among seniors fell from 34% in 1980 to 19% in 1994, about one in five Canadians aged 65 and over still had incomes below Statistics Canada's low income cut-offs in 1994.[7] Moreover, older unattached women are considerably more likely than their male counterparts to have low incomes. In 1994, 53% of unattached women aged 65 and over had low incomes, compared with 32% of unattached men.[8] If privatization means that

seniors will have to pay to get the health care they need, then those who are most likely to need health care are least likely to be able to afford it.

The National Advisory Council on Aging (NACA) believes that health care should be available to all on the basis of need rather than ability to pay, that providers of health care are accountable to the public for the services they provide, and that the criteria for evaluating health care must include quality and equity, as well as effectiveness and efficiency.

This paper sets out the position of NACA on privatization in health care in light of this belief. In particular, it examines the following issues:

- maintaining public funding for medically necessary services and defining "medically necessary";
- allocating adequate resources to community-based services;
- monitoring and evaluating the effects of private payments for health services; and
- ensuring quality and accountability in the delivery of community and institutional care.

The paper aims to identify clearly what mix of public and private should be maintained in the Canadian health care system, if that system is to continue to offer universal access to quality care for Canada's seniors. The paper draws on a number of sources of information: the work of the National Forum on Health, an informal consultation with seniors conducted by members of NACA on health care financing and delivery, an informal consultation with seniors conducted by members of NACA on seniors' and caregivers' values pertaining to health care,[9] a review of the literature on

private home care services,[10] and various studies in the fields of health economics and gerontology.

1. MAINTAINING PUBLICLY FUNDED HEALTH CARE ACCORDING TO THE PRINCIPLES OF THE *CANADA HEALTH ACT*

During the 1970s, there was an expansion of public financing for health services and health-related social services in Canada, extending coverage for hospital and physician services to include extended health care services (home care, ambulatory health services, intermediate care in nursing homes, and adult residential care) and health-related social services (home support services such as meals at home, help with clothing, transportation, personal care and home help). By the 1980s, most provinces had developed a system combining universally insured health services and means-tested health-related social services. The federal portion of universally insured health services was provided under the Established Programs Financing (EPF), while the federal portion of health-related social services was provided under the Canada Assistance Plan (CAP).

Various conditions applied to these federal transfers. In order to receive federal transfers for medically necessary services, provincial and territorial health insurance plans were obliged to comply with the criteria of the *Canada Health Act,* namely, universality, accessibility, comprehensiveness, portability, and public administration of health care in Canada. Federal contributions for extended health care services, on the other hand, were provided on a per capita basis and were not conditional on respecting the criteria of the *Canada Health Act.* To receive the federal contribution for health-related social services under the CAP, provincial and territorial governments had to provide welfare assistance solely on the basis of need, without imposing a minimum residency requirement, and to

maintain an appeals procedure. The decision of which services to provide and how to provide them was left to the provinces or territories.

In recent years, governments at all levels have had to restrain public spending. In particular, the federal government has combined the EPF and the CAP in a new block fund for health services, post-secondary education, and social services, called the Canada Health and Social Transfer (CHST), and has reduced the amount it transfers to the provinces and territories in this fund. Under the CHST, as under the EPF, federal tax revenues are transferred in two ways: cash payments and tax points. The cash payments give the federal government the means to maintain the principles of the *Canada Health Act*: provinces that compromise those principles by, for example, charging user fees can be penalized by an equivalent reduction in the cash payment. However, as part of its program to reduce expenditures, the federal government announced in 1996 that it would reduce its cash transfer to the provinces from $18.5 billion in 1995-96 to $12.5 billion in 1997-98, $11.8 billion in 1998-99, and $11.1 billion in 1999-2000. (More recently, the federal government has stated that CHST transfer payments will remain at 1997-98 levels, without further reductions.) The cuts that have been made to date not only reduce the funds (and consequently options) available to the provincial governments that are responsible for the delivery of health care, they also reduce the leverage that the federal government can exercise in maintaining national standards in health care.[11]

These developments raise a number of questions:

- Is Canada spending enough money on health care?
- Which health services should be considered "medically necessary?"
- If a greater range of health services are deemed medically necessary, where will the money be found to pay for these services?

1.1 Public Financing

Is Canada spending enough money on health care?

This question was considered by the National Forum on Health. It concluded that "Canadians are spending enough through their taxes and private payments to support access to needed health care"— relatively more than most industrialized countries at just under 10% of Gross Domestic Product.[12] Furthermore, the Forum also determined that the most effective way to control costs while still ensuring equity would be to maintain public funding of health care through the "single-payer" system currently in place in the provinces and territories. There is substantial evidence that a "single-payer" system, in addition to achieving equity, keeps costs down by reducing administrative costs, eliminating incentives to shift the cost of high-risk patients (such as the elderly) onto other payers, distributing the costs of health care more evenly throughout the economy, and providing greater bargaining power for the purchaser over the costs of services.[13]

The National Forum on Health observed:[14]

> The profit motive in financing health care is both inconsistent with a view of health as a public good and moreover leads to high administration costs and inequities in access and quality. International evidence suggests that public funding and administration are the best ways to achieve fairness and value for money.

NACA recommends that:

- **Medically necessary health services continue to be entirely publicly funded through a"single-payer" system at the provincial/territorial level.**

1.2 Medically Necessary Services

Which health care services should be considered "medically necessary?"

Currently most services provided by hospitals and physicians are considered medically necessary and are covered entirely by public insurance. In addition, certain other services — for example, drugs dispensed in hospitals or health care provided in a long-term care institution — are also covered entirely by public insurance. But the *Canada Health Act* only requires public insurance of medically necessary hospital and physician services; it does not require public funding of anything else. Public coverage for additional services such as prescription drugs dispensed outside of hospitals, dental care, eye care, and home care have varied from province to province. Provinces have provided them for particular groups, including seniors, but some form of private payment (a co-payment or a deductible) has usually been required.[15] Thus, in 1994, the ratio of public to private expenditures for health services was 90:10 for hospitals and 99:1 for physicians, but 70:30 for other

institutions (such as long-term care for seniors) and other services (such as home care), 32:68 for drugs, and 14:86 for other professionals (such as dentists or physiotherapists).[16]

The realities of health care in Canada have shifted considerably since 1984, when the *Canada Health Act* was passed with its focus on hospital and physician services. One noticeable change has been a shift away from institutional care, including hospitals, toward community care; less invasive medical techniques and shorter hospital stays have meant that Canadians receive more medical care in the community. Another marked change has been a dramatic increase in the share of expenditures on drugs, which have increased from 8.8% of total health expenditures in 1975 to 12.7% in 1994.[17] These changes have altered the balance of public and private funding for health care: many services that are deemed medically necessary today are not publicly insured because they are not provided in hospitals or by physicians.

Some have called the gradual devolution from hospital services to community services a form of "passive privatization" because it has the effect of de-insuring services that were once entirely publicly insured.[18] Clearly, there is much to be gained from technologies and therapies that command less institutional care. But it is essential that the definition of medically necessary services keep pace with the way services are now delivered. The Striking a Balance Working Group of the National Forum on Health found widespread support for the community health approach, but was also repeatedly told to "fund the care, not the institution."[19] Similarly, the National Forum on Health recognized that preserving and protecting health care means adapting to new realities, and recommended "expanding publicly funded services to include all medically necessary services and, in the first instance, home care and drugs."[20]

This recommendation has a number of implications for seniors. It has already been noted that seniors are more likely than younger individuals to have chronic illness, activity limitations, and physical disability. As a result, seniors, especially those aged 75 and older, use home care services more than younger Canadians, but the services seniors require are different. Personal care, housework, and meal preparation are used more as one grows older, whereas nursing care is used more by those who are younger.[21] These services prevent, delay, or replace more costly institutional services. For seniors, they must be included in the category of medically necessary home care services.

> *I have a homemaker for an hour in the morning, for the sponge bath. Once a week I have my shower, and they help me get dressed. See the things I have on my feet here; I have them cleaned, and I cannot do it myself, because my arm is so bad. My arms are almost useless. And I cannot put my shoes on until I have this done. Then I have one hour on three days during the week and one hour on the weekend to make me some supper. That's all, that's all the care I get.*[22] *(a senior)*

Similarly, prescription drugs may prevent or substitute for more costly institutional care. It is important that they be available to all who need them regardless of ability to pay. Currently, provincial drug plans cover the costs of drugs for seniors and welfare recipients; the remainder — 68% of expenditures in 1994 — is covered by private insurance or paid out-of-pocket. Most drug plans, both public and private, involve a degree of cost-sharing (an out-of-pocket expense) in the form of a user fee or a co-payment or a deductible.[23] This can be a hardship for seniors on low incomes, leading some to discontinue their medication, as NACA found in a recent consultation. Universal public funding of prescription drugs should eliminate such inequities.

> *Then they gave me medication but now the medication is very expensive. I can't get it anymore. With the new system, I can't afford to buy this medication. I take it only when I badly need it.*[24]

(a senior)

A recent study prepared by the Government of Alberta has found that lower-income seniors are at risk of financial hardship if they have high health needs or if they have unexpected emergency expenses, such as increased drug costs.[25] These results underscore the importance of public financing of home care and pharmacare.

There are other areas besides home care and drugs that should be included in discussions of medical necessity. These include technologies used to manage disease or disability such as monitoring and lifting devices, mobility aids, or hearing and vision aids. These technologies can enhance the independence and quality of life of seniors with disabilities and support informal caregivers.

NACA recommends that:

- **Publicly funded services be expanded to comprise all medically necessary services, including home care, prescription drugs and health technologies. The definition of medically necessary services should take the global health needs of seniors into account, including personal care and homemaking needs.**

1.3 Total Health Care Costs

If Canadians are already spending enough money on health care, and if a greater range of health services is deemed medically necessary, where will the money be found to pay for these services?

The answer to this question has to do not only with the amount of funds provided for health care, but also with the allocation of those funds, which will be discussed in greater detail in the next section of this paper. It is important, however, to reinforce a point made by the Striking a Balance Working Group of the National Forum on Health regarding the question of where money is to be found:

> Our priority is total costs versus government preoccupation with their own costs. System incentives, therefore, must ensure that patients are treated in the most appropriate, cost-effective setting, taking into account total public and private costs, both in financial terms and in terms of the burden on care givers, many of whom are women, and often elderly women.[26]

A recent report on the expense of caring for the elderly in Canada underscores this point. It concludes that families, and most often women, are bearing the costs of the shift from formal health care services to informal family caregiving for the elderly.[27] From the perspective of total costs of health care, this is merely a re-allocation of costs from the public sector to the private sector, and does not take into account hidden costs to the economy and to family caregivers such as unpaid labour, lost job opportunities, and out-of-pocket expenses. These hidden costs of health care privatization are of particular concern to NACA.

Universal public funding of health care services through a "single-payer" system has been shown to be the most effective means of controlling health care costs while maintaining equity and quality of services.[28] This lesson should not be forgotten as funding is realigned to correspond to the realities of health care today. Yet it is tempting to look for ways to increase the pot of money, rather than use the pot more wisely. User fees for home care services is one example of how governments have tried to increase the pot.

Although the *Canada Health Act* prohibits user fees for hospital and physician services, user fees may be, and are, applied to home care services. While 85% of home care services are publicly funded by provincial governments, 10% of these services are funded by user fees, and 5% by private insurance:

> Clients are usually charged a fee-for-service or user fee for non-clinical services such as homemaking, personal assistance and housecleaning, meals-on-wheels, transportation, and supplies and equipment. User fees are usually based on a sliding scale according to income.[29]

The disproportionate effect of this policy on seniors, who are the main users of non-clinical home care services, is evident.

At first glance, user fees seem to be a reasonable and effective way to reduce costs and increase funding for health care: user fees, it is argued, discourage unnecessary use of health services and increase the share of payment by people who can afford it. Indeed, an informal consultation conducted by NACA found that about one third of respondents supported user fees as a way to control health care costs. In fact, however, user fees have the effect of **increasing total health care costs** (by adding private costs without significantly reducing public costs) and **reducing access to health care among people of**

low income (who, although they are more likely to require health care, are less likely to be able to pay the user fee).[30]

One of the main reasons that user fees do not reduce costs is that costs are not driven up primarily by the number of people requesting health care. Rather, costs are driven up by the kinds of services offered those people. This has significant implications for seniors, since there is widespread concern about costs of health care rising as Canada's population ages. Studies indicate that the aging of the population in and of itself will not drive up costs significantly. What will drive up costs are the kinds of health services provided to the population — physician services, high technologies — that may not be the most appropriate and certainly are not the least expensive.[31] The provision of such services has more to do with the supply of these services and their appeal to health care providers than with the decisions or even needs of seniors.

Admittedly, it is not easy to realign health services without increasing the total amount of expenditures — public and private. As the Striking a Balance Working Group notes, "one dollar of expenditure on a good or service is one dollar of income for someone. Shifting the balance of expenditures therefore implies a change in the distribution of income."[32] People whose incomes are threatened by changes in health expenditures should be expected to resist such changes. In addition, transitions often require an infusion of money. The proposed move toward publicly funded insurance for prescription drugs is illustrative. As the National Forum on Health noted, implementing such a program would require investment in information systems and information technology, as well as the transfer of spending from individuals to governments. Government spending (and perhaps taxes) could well increase, although individual expenditures and total costs would probably decrease.[33] Consumers need to understand this as well as governments. The important

thing is to keep **total costs** in view and to ensure that the funding arrangements do not result in inequitable access to care or disproportionate burden of care.

NACA recommends that:

- **In expanding the coverage of medically necessary health services provided by a "single payer" system, provincial and territorial governments consider the positive effects of public funding in controlling total health care costs and in reducing the potentially disproportionate burden of the private costs of care on seniors and their informal caregivers.**

2. ALLOCATING NECESSARY FUNDS TO COMMUNITY-BASED SERVICES

The line between health care services and health-related social services is not a clear and definite one, particularly for seniors.[34] Research into the determinants of health in older age has shown that personal health practices and the socio-economic environment have profound effects on the health and well-being of seniors.[35] Social support for seniors can assist them in maintaining social ties, eating well, coping with physical decline or chronic illness, and preserving self-esteem and a sense of control. All of these factors contribute indirectly to preventing or controlling illness and to maintaining independence in older age.

Informal caregivers — spouses, families, friends — already attend to about 80% of the care needs of seniors.[36] NACA is concerned that, in the absence of adequate allocations to community-based health services, the financial burden (out-of-pocket expenses) and economic costs (lost wages, missed job opportunities) borne by informal caregivers will increase. NACA is also concerned that the balance between institutional and community-

based services, as well as the balance among community-based services, will not correspond to the needs of seniors who require more support in their homes.[37] This could well result in higher institutional costs, as seniors who otherwise could remain in their homes turn to institutions for care.[38]

> *Well, I have been really worried when you hear all this talk of cut-backs and so on. I mean, I need every ounce of back-up I can get these days. Every hour of the day is crucial, and if any one of those three programs that I use falls down, I am dead in the water. I feel as if we're very vulnerable and dependent of the systems that we have in place right now. So I don't have much room to manoeuvre. In fact, I feel I am right on the edge of keeping things going as it is.*
> *(an informal caregiver)*
>
> *It would be money down the drain for everybody (if I'd had to put her in a home sooner). And we'll be finishing off, truncating a person's life prematurely and unnecessarily. You're dealing with a person's life here. Every day I keep her at home, I feel I am giving her another day of normal life.*[39]
> *(an informal caregiver)*

There are a number of forces at work here. First, there is the move toward block funding under the CHST. It has already been noted that many community-based health care services used by seniors are currently not deemed medically necessary but are nevertheless partially covered by provincial insurance plans. In addition, provincial governments provide community-based social services to seniors on the basis of need. Under the previous EPF and CAP, there were incentives for the provinces to provide these further services. With the CHST, these incentives have been removed. Provinces now receive block funding with no restrictions on how they allocate these funds. Provinces are obliged to provide medically necessary health care services in accordance with the *Canada Health Act,* and are prohibited from imposing a residency requirement for social services, but otherwise they are free to allocate the funds transferred under the CHST as they see fit

to health, education, or social services. There is some concern that social services will come out last under this arrangement.[40]

Second, the allocation of resources to community-based health care services has not kept pace with the demand for those services.[41] Although provinces have increased their allocation for home care many times over the last decade, home care still represents a small percentage of total health services.[42] Between 1975 and 1994 the share of national health expenditures spent on hospitals decreased by 7.7 percentage points (from 44.9% to 37.2%), while the share spent on home care increased only by 1.1 percentage points (from 0.3% to 1.4%); the share spent on other institutions (mostly nursing homes for seniors) has increased a slight 0.6 percentage point (from 9.2% to 9.8%).[43] *The NACA Position on Community Services in Health Care for Seniors: Progress and Challenges* (1995) noted some of the consequences of this failure to allocate adequate resources to community-based services: poor after-care for patients discharged from hospital, greater burden of care for informal caregivers, and greater likelihood of institutionalization.[44] As gerontologist Neena Chappell has observed, "If medical care is cut back without an expansion of community care, seniors are left not with a new health care system, simply a less adequate old one."[45]

Third, the very trends that have led to a decrease in institutional health care services have created competition for resources among community-based services.

There are different models of home care, each with their own goals and functions:[46]

> the **maintenance and preventive model**, which serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently, and in many cases preventing health and functional breakdowns and eventual institutionalization;
>
> the **long-term substitution model**, where home care meets the needs of people who would otherwise require institutionalization; and
>
> the **acute-care substitution model**, where home care meets the needs of people who would otherwise have to remain in, or enter, acute-care facilities.

The demand for both acute-care substitution services and long-term substitution services has been growing.[47] On the one hand, shorter hospital stays and subsequent convalescent care have created a need for acute-care substitution services. On the other hand, a declining ratio of long-term beds in relation to a growing number of elderly has increased the need for long-term substitution services. In the competition for resources, there is a risk that acute-care needs will be met first, and that maintenance or preventive needs will be met last. The incentives to provide acute-care substitution services — urgent need, quantifiable and controlled services, and a more certain profit margin (in the case of for-profit services[48]) — may be stronger than the benefits of such mundane services as homemaking, shopping, recreational, or reassurance services.

These developments underscore the need for comprehensive and participatory planning of health and social services, including community-based services, that reflects and responds to needs at the regional level. Again, *The NACA Position on Community*

Services in Health Care for Seniors: Progress and Challenges (1995) made a number of recommendations that are still valid today. Indeed, the essence of these recommendations — a comprehensive definition of medically necessary services, maintenance of universal public insurance for these services, a single point of entry to all services, allocation of resources at the regional level based on overall needs, and the participation of users of health services in the determination of needs and allocations — is consistent with the recent findings of the National Forum on Health.[49]

NACA reiterates the recommendations that:

- **Provincial/territorial governments ensure that senior consumers be fully represented in local health decision-making and planning.**

- **Provinces and territories provide a core package of services that covers the continuum of care in all regions, establish province-wide standards and protocols and monitor compliance to these standards and protocols.**

- **Single-entry models of access to all services be made available in every community, to assure that seniors have access to the full continuum of care.**

- **Provincial/territorial governments allocate the funding required to meet the needs of each region for community-based services.**

- **Provincial governments and regional health boards involve the community care sector as a full and equal partner in all health care decision-making and planning.**

- **The federal government set national standards governing accessibility and the provision of a core package of services for the transfer of funds to the provinces/territories for social and health-related services.**

3. MONITORING AND EVALUATING THE EFFECTS OF PRIVATE PAYMENTS FOR HEALTH SERVICES

Under the terms of the *Canada Health Act,* provincial and territorial governments are discouraged from permitting private payments — user fees, extra billings, and so on — in addition to public payments for medically necessary services. This should continue to be the policy when the definition of medically necessary services is expanded to include such things as home care and drugs. Currently, however, additional private payments are required for a number of publicly funded health care services that seniors rely upon, and some services have been entirely "de-insured" (that is, they are no longer covered by public insurance and must be paid out-of-pocket or by private insurance).

3.1 Private Payments For Long-term or Hospital Accommodation

Seniors make up the majority of Canadians living in a hospital or an institution providing long-term care. In 1991, 8.1% of seniors aged 65 and over were living in an institution, mostly in special care homes. They represented 58% of all people in Canada living in an institution.[50] The proportion of seniors in institutional settings increases with age. In 1991, 2.7% of people aged 65 to 74, 10.4% of people aged 75 to 84, and 36.6% of people aged 85 and over lived in an institution. Senior women aged 85 and over are the most likely people to be living in an institution — in 1991, 41% of these women were living in an institution — and, overall, senior women are more likely to be living in an institution than senior men.[51]

People living in long-term care institutions are charged residency fees according to provincial or territorial fee schedules. There is currently no consistency from province to province in the rates charged or in the method of fee assessment. In some jurisdictions, fees are set according to income whereas in others, everyone pays a standard rate; in some provinces, assets are also considered in the calculation of total income.[52] There is evidence from Alberta that facility fees may impose a financial hardship on many seniors. In this province, where there is a standard fee for institutional accommodation, it has been shown that seniors with low incomes can face a financial hardship if they and/or their spouse live in continuing care facilities or if they have to spend short periods of time in these facilities.[53]

People who remain in hospital for long periods of time awaiting discharge may be charged for the accommodation provided while they wait. This practice penalizes the individual for factors outside the individual's control, such as the lack of appropriate discharge planning or the lack of beds in long-term care facilities.

NACA recommends that:

- **Provincial and territorial ministries of health monitor and evaluate trends in out-of-pocket charges for long-term or hospital accommodation.**

- **Provincial and territorial ministries of health develop a payment schedule for long-term care or hospital accommodation that ensures fair and affordable access for all residents and that does not penalize individuals for gaps in the continuum of care, such as inadequacies in discharge planning or in long-term care places.**

3.2 De-insuring Medical Services

Provinces and territories have reduced the public portion of health care expenditures by de-insuring medical services not included under the *Canada Health Act.* For example, a number of provinces have totally or partially de-insured services such as routine eye examinations (except for children and seniors), podiatry and physical therapy. There is evidence that de-insuring services has increased total health care costs, although it may have decreased public health care costs. A convenience sample surveyed by the Consumer Association of Canada (Alberta) found that after Alberta Health de-insured routine eye examinations, the average price for the examinations rose by about 30%.[54] As well, de-insurance introduces inequity into health care, since the cost of de-insured services will be relatively greater for people with lower incomes than for those with higher incomes.

When one province has de-insured a medical service, there may be a tendency for other provinces to follow suit. This, together with a lack of adequate monitoring of the consequences of de-insuring a medical service, can lead to policies that fail to take true costs and eventual consequences into account. It would be far better if these decisions were taken collaboratively by the provinces based on criteria and data that account for the impact of de-insuring on health, quality of life, potential illness, equity of and access to health care, and total health care costs. If the provinces are unable to come to an agreement, this is probably an indication that, as many have argued, the only effective means to maintain national standards of health care is the leverage that the federal government can exert through the transfer payments made under the CHST.[55]

NACA recommends that:

- **Federal, provincial and territorial ministries of health collaborate in developing criteria for decisions to de-insure health services and monitoring the impact of those decisions. The criteria should include the effects on health, quality of life, potential illness, equity of and access to health care, and total (public and private) health care costs.**

4. ENSURING QUALITY AND ACCOUNTABILITY IN THE DELIVERY OF COMMUNITY AND INSTITUTIONAL CARE

Currently, there is a mix of public, private for-profit and private non-profit health services, both community-based and institutional. As these services increasingly compete for government funding, NACA is concerned that cost pressures may be eclipsing quality of care.

Government-funded coordinated home care programs (CHCPs) provide more than 90% of home care services in Canada. Most of these programs — 381 of the more than 400 CHCPs in Canada — are affiliated with community-based agencies. The large majority of CHCPs are administered by official government health agencies and locally elected community health boards. Typically, these agencies and their staff are responsible for coordinating, contracting out, and monitoring services. In all but two provinces, CHCP staff provide the majority of professional services, such as nursing and rehabilitation services, while most of the home support and ancillary services, such as homemaker, home help, meals-on-wheels, drugs, dressings, and supplies and equipment, are purchased from or arranged with external agencies.[56]

The provision of community-based services by private for-profit agencies is a cause of concern to NACA. A review of the privatization of public services in the United States under the Reagan Administration concluded that for-profit agencies are more efficient in providing straightforward, measurable, and easily monitored services such as garbage collection and data processing, but that non-profit agencies are more efficient at providing more complex social welfare services such as nursing home services.[57] There have been few studies comparing non-profit and for-profit home care services. One American study found that non-profit home nursing agencies served more medicaid (welfare), self-pay, and indigent clients, and made twice as many visits per client, than for-profit agencies.[58]

The public appears to accept private delivery of home care services as long as the government is involved in case management and quality control.[59] NACA wishes to emphasize several aspects of this responsibility pertaining to:

- regulation, management, standards, and evaluation; and
- working conditions, staff supervision, and staff training.

4.1 Regulation, Management, Standards, and Evaluation

As the delivery of health shifts from hospitals and other institutions to a diverse array of public, non-profit, and for-profit providers of community-based services, it is important that provincial and territorial governments regulate and coordinate the delivery of care across the entire continuum of care. Most provinces have moved toward "coordinated assessment and placement systems, coordinated case management programs, a single administration for continuing care and consistent care level classification systems which are the ingredients for the most cost effective and efficient service delivery mechanisms and systems."[60] As well, governments have remained involved in the competitive processes whereby home care contracts are awarded, so as to ensure that certain publicly desired outcomes are achieved and quality care is maintained.[61] This public involvement in

the regulation and management of home care must continue to ensure high-quality, cost-effective services.

In addition, progress is being made in the development of standards and in the accreditation of community-based services. A program of standards and accreditation for home care organizations, and a similar program for community health services now exist. Standards for mental health and rehabilitation services have also been prepared and are available from the Canadian Council on Health Services Accreditation. However, home care standards do not exist in all provinces and territories, and systems are needed to gather the information required to monitor whether standards are being met.[62]

Measuring and evaluating the outcomes of home care services is often more difficult than measuring and evaluating outcomes of other kinds of health services. Seniors may have complex needs that require a range of medical services, personal care, functional assistance, and emotional reassurance. The outcome of care may not be achieving complete health, but may rather be improving quality of life. In assessing the quality of care in such circumstances, the perspective of the client must be taken into account.

NACA recently carried out an informal consultation with seniors and their informal caregivers on what they value in their experience of formal and informal health care.[63] The report documents how seniors value services that are effective, sufficient (no more than necessary), available, predictable, flexible, affordable, and delivered at the right time. Seniors also value care providers who communicate clearly and honestly, are caring, anticipate future needs, inspire confidence, and "go the extra mile."

The report on the consultation recommends that "researchers be encouraged to consistently involve seniors and their caregivers in planning and conducting research that concerns their issues."[64] This applies especially to the evaluation of community-based services, which should measure not only improvements in health status but also less

tangible outcomes such as effects on the quality of life of seniors and their informal caregivers and the qualities of the relationship between seniors and their formal care providers.[65] Research into the quality of care has tended to focus on the outcomes of care rather than the process of care. The process of care "refers to how care is provided and includes how the caregiver relates to the client as well as his or her competency in performing needed tasks."[66] Studies have found that the competence of the care provider, a compatible relationship between client and care provider, and continuity in the care that is provided, are important to older recipients of home care.[67] Community-based services should be evaluated on how they meet these needs expressed by seniors, as well as the needs perceived by their informal caregivers.

NACA recommends that:

- **Provincial and territorial governments take a major role in the public regulation of home care services, the management of competitive contracting processes and the management of monitoring and accountability processes, in order to ensure quality of care, equitable access to care, and timeliness of services.**

- **Provincial and territorial governments develop standards and evaluate services for home care that involve seniors and their informal caregivers, as well as professional care providers and agency administrators, to ensure that effects on quality of life are taken into account along with effects on health status.**

4.2 Working Conditions, Staff Supervision, and Staff Training

Evaluations of home care agencies should take into account not only the needs of clients, but also the requirements of those who provide direct care. Home care workers are, in

general, poorly paid, work long hours, and enjoy few benefits.[68] Most of them are women. They often work in isolation, with minimal supervision and support, and with little training.[69] Moreover, they are required to deal with a wide variety of clients, including the technologically dependent person, the early discharge acute-care patient, the disabled, the frail, and the elderly.

In 1995, the Canadian Association for Community Care met with 155 home support workers and 50 managers and supervisors from 35 agencies across Canada to assess their needs. A major focus of discussion with the home support workers was the stress of their work. The level of stress depended on whether certain systems and policies were in place, irrespective of whether the agency was for-profit or non-profit, small or large, urban or rural, and unionized or non-unionized. Lack of supervision and training, no allowance or support to grieve for a client who had died, low wages and few benefits, lack of recognition from other members of the team of providers, exclusion from participating in case management, coping with tasks that were technologically complex, threats to personal safety — all of these contributed to the workers' stress.[70] Managers, for their part, spoke of trying to meet the income needs of their workers, arranging schedules, counselling workers on the limits of their relationship with their client, and being concerned about possible physical and emotional burnout of their workers.[71]

This study points to the need for good supervision and support, adequate training, manageable schedules, and fair wages for paraprofessional home care workers. To date, there has been little research on the effects of privatization on these aspects of the working conditions of the paraprofessional home care worker. It is noteworthy, however, that an overview of the financial state of for-profit home care providers in the United States found that unskilled home care providers were less profitable and under more financial pressure than providers of high-technology or standard medical care.[72] The service is characterized by high labour turnover and entrenched worker poverty, and this has in turn compromised quality, reliability, and availability of services:

> As one provider put it, the poorly paid home care worker is "subsidizing the cost of home care." Alternatively, the elderly patient is receiving lower quality of care due to the financial limits on providers, which prevents them from improving worker conditions.[73]

At the very least this suggests that in evaluating the delivery of home care, it is important to measure the effects of provincial fee schedules, wages and benefits, job supervision, and staff training on the working conditions of the care provider and, indirectly, the quality of care provided.

NACA recommends that:

- **Provincial and territorial governments develop indicators pertaining to the relative allocation of resources to client services, staff remuneration, staff accreditation, and staff training and support to assess quality of care and to award contracts for home care services.**

- **Provincial and territorial governments provide sufficient resources for home care to ensure adequate remuneration and appropriate training of paid caregivers, and to avoid shifting the burden of home care to low-paid workers or unpaid caregivers, most of whom are women.**

Although the Council has not been able to document the trends towards privatization in institutional long-term care as thoroughly at this time, available evidence suggests that similar issues related to quality of care are emerging from privatization. In this context, NACA believes that all the recommendations proposed for quality control of home care are applicable to institutional care.

CONCLUSION

As the realities of health care change, so must the funding, allocation, and delivery of health services. In considering all these dimensions of the discussions on the privatization of health care, NACA judges that changes can be made without increasing total (public and private) health care costs, without diminishing the comprehensiveness and universality of medically necessary services, without compromising the kinds of services (particularly home care) that seniors require, and without increasing the share of costs that low-income seniors bear relative to high-income seniors. The recommendations put forward in this position paper identify specific ways in which federal, provincial, and territorial governments can ensure that, as they reform Canada's health care system, the mix of public and private contributes to, rather than detracts from, the further achievement of universal access to health care based on need rather than ability to pay.

NOTES

1) The Striking a Balance Working Group of the National Forum on Health, established partly because of concern "that the balance between public and private financing for health care was shifting by accident, rather than by design, thereby threatening nation-wide entitlement to universal access to health care based on need," noted that "Most discussion about privatization is based on an emotional and emphatic rejection of the American health system," even though Canada is "nowhere near the levels of private financing that characterize the American system."

   Lewis, S. et al. Striking a Balance Working Group Synthesis Report. In *Canada Health Action: Building on the Legacy.* Vol. 2: *Synthesis Reports and Issues Papers.* Ottawa: National Forum on Health, 1996: 3, 35.

2) National Forum on Health. *The Public and Private Financing of Canada's Health System: A Discussion Paper.* Ottawa: 1995.

3) Wilkins, K., and E. Park. Chronic conditions, physical limitations and dependency among seniors living in the community. *Health Reports*, Winter, 1996, Vol. 8, No. 3.

4) "The propensity to suffer different levels of functional limitation is highly associated with poverty. There are consistent associations between higher odds of poor health and the proportion falling below low income standards or having less education. ... Particularly important to this analysis of disadvantage has been the continued increase in the concentration of elderly women living alone. ... This concentration of women living alone is significant because, while this group has relatively greater functional independence, it also makes much more use of formal agencies than do other groups."

   Moore, E. G., Rosenberg, M. W. and D. McGuinness. *Growing Old in Canada: Demographic and Geographic Perspectives.* Ottawa: Statistics Canada, 1997: 156; cf. 140-146.

5) Renaud, M. et al. Determinants of Health Working Group Synthesis Report. In *Canada Health Action: Building on the Legacy.* Vol. 2: *Synthesis Reports and Issues Papers.* Ottawa: National Forum on Health, 1996: 3.

6) Lindsay, C. *A Portrait of Seniors in Canada.* 2nd ed. Ottawa: Statistics Canada, 1997: 61, 77.

7) Lindsay, C., *op. cit.*, p. 101.

8) Lindsay, C., *op. cit.*, pp. 101-102.

9) Gallagher, E. M. Seniors' & Caregivers' Values Pertaining to Health Care: An Informal NACA Consultation. A Report Prepared for the National Advisory Council on Aging and the Division of Aging and Seniors, Health Canada. February, 1997.

10) Nahmiash, D. An Updated Review of the Literature and Documentation on Private Home Care Services in Canada. Report to the Division of Aging and Seniors, Health Canada, 1996.

11) Over the past decade the ratio of the federal cash transfer as a percentage of provincial health care spending has been steadily declining, from 33% of provincial health care expenditures in 1984 to 21% in 1995. This trend accelerated under the CHST.

Maslove, A. M. The Canada Health And Social Transfer: Forcing Issues. In G. Swimmer, ed., *How Ottawa Spends 1996-97: Life Under the Knife.* Ottawa: Carleton University Press, 1996: 283-301.

12) National Forum on Health. *Canada Health Action: Building on the Legacy.* Vol. 1: *The Final Report of the National Forum on Health.* Ottawa: 1996: 12.

13) Deber, R. et al. The Public-Private Mix in Health Care: Report to the National Health Forum. Toronto: Department of Health Administration, University of Toronto, 1996: 2-12-13.

14) National Forum on Health. *Canada Health Action: Building on the Legacy.* Vol. 1: *The Final Report of the National Forum on Health,* pp. 11-12.

15) National Forum on Health. *The Public and Private Financing of Canada's Health System,* pp. 6-7.

16) Lewis, S. et al., *op. cit.,* p. 15.

17) Lewis, S. et al., *op. cit.,* pp. 13-14.

18) Deber, R. et al., *op. cit.,* p. 3-5.

19) Lewis, S. et al., *op. cit.,* p. 36.

20) National Forum on Health. *Canada Health Action: Building on the Legacy.* Vol. 1: *The Final Report of the National Forum on Health,* p. 20.

21) In 1994-95, 3% of the Canadian population (about 641,000 people) used home care services. Six percent of people aged 65-74 and 18% of people aged 75 and above used home care, compared to 2% or less of people under the age of 65. The percentage who report using nursing care and housework services respectively, by age group, was 91% and 0% (age 18-19), 72% and 20% (age 20-24), 59% and 25% (age 25-44), 49% and 36% (age 45-64), 35% and 61% (age 65-74), and 25% and 62% (age 74 and over).

Federal, Provincial and Territorial Advisory Committee on Population Health. *Report on the Health of Canadians: Technical Appendix.* Ottawa: Health Canada, 1996: 143-145.

22) Gallagher, E. M., *op. cit.,* p. 14.

23) Deber, R. et al., *op. cit.,* p. 5-16.

24) Gallagher, E. M., *op. cit.,* pp. 30-31.

25) Alberta Community Development. *Review of cumulative impact of program and service changes on seniors.* November, 1996.

26) Lewis, S. et al., *op. cit.,* p. 37.

27) Women Bear Brunt of Elder-Care Woes. *The Globe and Mail.* Thursday, March 27, 1997: A1, A7.

28) Evans, R. G. Hang Together, or Hang Separately: The Viability of a Universal Health Care System in an Aging Society. *Canadian Public Policy - Analyse de Politiques*, 13, 2 (1987): 165-180.

29) Sorochan, M. W., Home Care in Canada, *Caring,* 1 (1995): 16.

30) Stoddart, G. L. et al. *Why Not User Charges? The Real Issues.* Toronto: The Premier's Council on Health, Well-being and Social Justice, 1993.

31) Evans, R. G., *op. cit.* See also the studies cited in National Advisory Council on Aging, *The NACA Position on Health Care Technology and Aging,* Ottawa: 1995, p. 20.

[Note also E. Leibovich et al., Health Care Expenditures and the Aging Population in Canada, *Papers Commissioned by the National Forum on Health,* Ottawa: 1997.]

32) Lewis, S. et al., *op. cit.,* p. 10.

33) National Forum on Health. *Canada Health Action: Building on the Legacy.* Vol. 1: *The Final Report of the National Forum on Health,* pp. 22-23.

34) "If society is really serious about promoting well-being and population health, there needs to be a reconfiguration of resources throughout the economy, not just the health sector. ... the boundaries between health and other sectors are not clearly delineated, particularly in the case of prevention and health promotion, as well as services for seniors, the frail elderly and the chronically ill."

S. Lewis et al., *op. cit.,* p. 10.

35) Chappell, N. L. Maintaining and Enhancing Independence and Well-Being in Old Age. In *What Determines Health? Summaries of a Series of Papers on the Determinants of Health Commissioned by the National Forum on Health.* Ottawa: National Forum on Health, 1996: 52-56.

36) Canada Seniors. *Ageing and Independence: Overview of a National Survey.* Ottawa: Health and Welfare Canada, 1991.

37) "Community-based services are services which are provided to persons living in the community to help individuals maintain or regain a maximum degree of autonomy and independence by addressing their physical, mental or social needs. These services broadly include information and referral services, co-ordination services, services of health professionals, as well as a variety of other support services (personal and social support, housing services, health promotion, respite services and transportation). These services are organized, funded and delivered from a base in the community."

    National Advisory Council on Aging. *The NACA Position on Community Services in Health Care for Seniors: Progress and Challenges.* Ottawa: 1995: 9.

38) Research has found that provision of formal community-based services does not reduce, and may increase, the amount of care provided by relatives and friends, whereas the absence of formal community-based services can result in reduced levels of informal care and, when the burden of care is very heavy, complete withdrawal of informal care.

    Canadian research has also shown that community-based care substitutes for long-term facility use, that long-term facility admission and adult day care substitute for hospital admission (particularly for people aged 75 years and older), that community-based care costs on average one-tenth the cost of long-term facility care, and that long-term facility care is less costly than hospital care.

    Shapiro, E. Community and Long-Term Health Care in Canada. In Blomqvist, Å. and D. M. Brown, eds. *Limits to Care: Reforming Canada's Health System in an Age of Restraint.* Toronto: C. D. Howe Institute, 1994: 341-343, 345-346. See also E. Shapiro's response to W. G. Weissert. Cost-effectiveness of Home Care. In Deber, R. B., and G. G. Thompson, eds. *Restructuring Canada's Health Services System: How Do We Get There From Here?* Toronto: University of Toronto Press, 1992: 89-108.

39) Gallagher, E. M., *op. cit.,* p. 51.

40) Maslove, A. M., *op. cit.,* pp. 290-291.

41) National Advisory Council on Aging, *op. cit.,* p. 14. Sorochan, M. W., *op. cit.,* p. 19.

42) There has been a considerable increase in provincial funding for home care services over the past ten years. In Ontario the home care budget grew 669% from $104 million in 1984-85

to $800 million in 1995-96. In Saskatchewan the home care budget grew 249% from $17.4 million to $60.8 million in the same period. From 1988-89 to 1995-96 the home care budget in Nova Scotia grew 415% from $8 million to $44 million.

Nahmiash, D., *op. cit.,* p. 17.

43) Lewis, S. et al., *op. cit.,* pp. 13-14.

44) National Advisory Council on Aging, *op. cit.,* pp. 15-16.

45) National Advisory Council on Aging, *op. cit.,* p. 14.

46) Health and Welfare Canada. *Report on Home Care.* Ottawa: Supply and Services Canada, 1990.

47) Shapiro, E. Community and Long-Term Health Care in Canada, pp. 348-349.

48) Kane, N. M. The Home Care Crisis of the Nineties. *The Gerontologist,* 29, 1 (1989): 24-31.

49) National Forum on Health. *Canada Health Action: Building on the Legacy.* Vol. 1: *The Final Report of the National Forum on Health,* pp. 21-22.

50) Lindsay, C., *op. cit.,* pp. 27, 33.

51) The proportion of women living in an institution is greater than the proportion of men, and the difference increases with age: 2.8% women v. 2.6% men among those aged 65-74, 12.1% women v. 7.9% men among those aged 75-84, and 40.9% women v. 26.8% men among those aged 85 and over.

Lindsay, C., *op. cit.,* pp. 27, 33.

52) Nova Scotia, Prince Edward Island and New Brunswick consider income from all sources, including all liquid and tangible assets except the principal residence, in the assessment of facility fees. Quebec exempts the value of the principal residence, up to $40,000. Newfoundland includes liquid assets/ investment income, but not fixed or tangible assets. Ontario, Manitoba, Saskatchewan and British Columbia set fees on the basis of net after-tax income. Alberta, the Yukon and the Northwest Territories have established standard fees for all residents, regardless of income. In Alberta, accommodation rates are set at the income of seniors receiving Old Age Security, the Guaranteed Income Supplement and the provincial supplement. In the Yukon, the fee is lower than the combination of OAS and GIS. In the Northwest Territories, the fee is set at the average of the three lowest rates in Canada.

53) Alberta Community Development, *op. cit.*

54) "The Consumer Association of Canada (Alberta) surveyed a convenience sample of 72 optometry and 22 ophthalmology clinics between May 8 and May 12, 1995 .... Prior to

December 1994, optometrists and ophthalmologists were reimbursed $35.94 by Alberta Health for basic eye exams. After that date, care moved to the private market. Prices rose an average of $10.76 (29.94%) for the 74 optometrists and $11.20 (31.16%) for the 22 ophthalmologists. Waiting times were short, often same day or next day, and rarely more than one week. Anecdotally, prices also rose in Saskatchewan after eye examinations were de-insured ...."

Deber, R. et al., *op. cit.,* p. 5-11.

55) "There is no viable alternative to federal-provincial transfers if we are truly serious about maintaining national health care principles as we know them. Interprovincial agreements, despite best intentions, would likely evolve toward an increasingly minimalist interpretation of national requirements as provinces, over time, experience different economic circumstances, priorities and political preferences."

Lewis, S. et al., *op. cit.,* p. 28.

56) Sorochan, M. W., *op. cit.,* pp. 12, 14-15.

57) Bendick, M., Jr. Privatizing the Delivery of Social Welfare Services: An Ideal to be Taken Seriously. In Kamerman, S. B. and A. J. Kahn, eds. *Privatization and the Welfare State.* Princeton, N. J.: Princeton University Press, 1989: 97-120.

58) Shuster, G. F., III, and P. A. Cloonan. Home Health Nursing Care: A Comparison of Not-for-Profit and For-Profit Agencies. *Home Health Care Services Quarterly,* 12, 1 (1991): 23-36.

59) Larsen, L. Home Care in Canada: New Challenges and Emerging Opportunities. The Annual Home Care Management Conference, New York State Association of Health Care Providers. 1996. Cited in D. Nahmiash, *op. cit.,* p. 16.

60) Nahmiash, D., *op. cit.,* p. 18.

61) Nahmiash, D., *op. cit.,* pp. 13-14.

62) Nahmiash, D., *op. cit.,* p. 30.

63) Gallagher, E. M., *op. cit.*

64) Gallagher, E. M., *op. cit.,* p. 58.

65) D. Nahmiash, *op. cit.,* p. 33.

66) Eustis, N. N., and L. R. Fischer. Relationships Between Home Care Clients and Their Workers: Implications for Quality of Care. *The Gerontologist,* 31 (1991), 447-456: 447.

67) Penning, M. J., and N. L. Chappell. *Home Support Services in the Capital Regional District: Client Survey. Final Report.* Victoria: University of Victoria Centre on Aging, 1996: 4-5, 43.

68) Kane, N. M., *op. cit.,* describes the situation in the United States. In Canada home care workers in some provinces have unionized and have succeeded in obtaining pay increases, regular hours, and fringe benefits. See E. Shapiro, Community and Long-Term Health Care in Canada, pp. 347-348.

69) HomeSupport Canada. Literature Review on the Role of Health Promotion and the Home Care/Support Worker. In Canadian Association for Community Care, *Health Promotion and the Home Support Worker.* Ottawa: 1995.

70) Canadian Association for Community Care, *op. cit.,* p. 10-15.

71) Canadian Association for Community Care, *op. cit.,* pp. 19-20.

72) Kane, N. M., *op. cit.*

73) Kane, N. M., *op. cit.,* p. 30.

POSITION PAPERS
OF THE
NATIONAL ADVISORY COUNCIL ON AGING

7. The NACA Position on the Goods and Services Tax, February 1990.

8. The NACA Position on Community Services in Health Care for Seniors, February 1990.

9. The NACA Position on Informal Caregiving: Support and Enhancement, September 1990.

10. The NACA Position on Lifelong Learning, October 1990.

11. The NACA Position on Gerontology Education, December 1991.

12. The NACA Position on Managing an Aging Labour Force, February 1992.

13 The NACA Position on Canada's Oldest Seniors: Maintaining the Quality of their Lives, January 1993.

14. The NACA Position on the Image of Aging, February 1993.

15. The NACA Position on Women's Life-Course Events, September 1993.

16. The NACA Position on Community Services in Health Care for Seniors: Progress and Challenges, February 1995.

17. The NACA Position on Determining Priorities in Health Care: The Seniors' Perspective, February 1995.

18. The NACA Position on Health Care Technology and Aging, May 1995.

19. The NACA Position on the Privatization of Health Care, October 1997.