

**FEDERAL-PROVINCIAL-TERRITORIAL
ADVISORY COMMITTEE ON HEALTH SERVICES (ACHS)
WORKING GROUP ON CONTINUING CARE**

**The Identification and Analysis of Incentives
and Disincentives and Cost-Effectiveness of
Various Funding Approaches for Continuing Care**

**Technical Report 2: The Public-Private Split in
Continuing Care – Case Studies of Nova Scotia and Alberta**

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EXECUTIVE SUMMARY

The purpose of this case study was to examine the nature of the public-private split in continuing care in Nova Scotia and Alberta. This is one of three case studies being conducted as part of the Health Canada study of incentives and disincentives in continuing care in Canada, which also includes a national survey of the continuing care sector. The overall purpose of the Incentives/Disincentives project was to provide more evidence-based discussion of key issues surrounding various approaches to the funding of continuing care in Canada. The material provided by the entire study will be used to inform our understanding of client care and health benefit objectives, assist providers and clients with further knowledge on the sites of continuing care, and enhance our awareness of the issues surrounding the public/private system of funding continuing care services. The two provinces for this case study were selected because they reflect very different approaches to continuing care.

At the heart of the public-private issue is the nature and extent of *rationing* - whereby resources are finite, and yet a range of needs and wants by society will exist. The public sector (i.e., government), which governs the supply and distribution of the public's health care resources, makes a public decision about what to fund and what not to fund. For Canadians, the key issue is "not whether the supply is limited (rationed), but whether the limits are reasonable, affordable, ethical and able to meet the health care needs of the population" (National Forum on Health, 1995:10). To many observers, 'private' typically equates to 'for-profit', but in reality 'private' can have many different meanings stemming from both the payment mechanism and the provision of services (see Evans et al., 2000).

The key informants for the profile of Nova Scotia were selected from the home care and long term care sector and include policy makers, service/program deliverers and representatives from advocacy organizations. Attention was given to obtaining respondents from public and private sectors (for-profit and not-for-profit), as well as those representing larger and smaller organizations. One of the difficulties in interviewing a range of service providers is their responses to the equity and appropriateness of the current system are often contingent upon the interests of the group that they represent. Face-to-face interviews were held with 16 individuals and telephone interviews were held with 3 individuals. The interviews were approximately one hour in duration and took place in January and February 2000. A pre-established list of questions guided the interview. The profile of Alberta was based on a series of semi-structured face-to-face and telephone interviews conducted with stakeholders in continuing care in Alberta. These stakeholders came from government, regional health authorities, for-profit and not-for-profit organizations, public agencies and associations. In total, 24 stakeholder organizations were interviewed in February and March 2000.

Seven key dimensions provide the context in which the split between public and private roles in health care is evolving: demographic imperatives, fiscal imperatives, political context, ideology, human resources, evolution and vision, and access. In both Nova Scotia and Alberta the environment is currently conducive for increased levels of privatization (and profitization). The extent to which this occurs, however, will be predicated on the population's engagement in the political process to

determine how care should best be provided. Indeed, at the time of writing the Albertan government is being taken to task by the public with regards to perceived profitization through Bill 11.

The classification of public and private outlined by Deber et al. (1998) is useful for examining the differences between Alberta and Nova Scotia. At a broader level, the jurisdiction for continuing care is a provincial responsibility - the *Canada Health Act* legislated by the federal level does not apply to continuing care services. Within these two provinces, Alberta has devolved the responsibility for continuing care to the regional level, while Nova Scotia continues to centralize decision making in continuing care services. Consequently, following the geographical logic outlined by Deber et al., the public involvement in Alberta must be recognized at provincial and regional levels. This additional layer raises the complexity of discussing one policy of private-public involvement in continuing care services. While Nova Scotia does not have the additional complexity of regionalized financing and delivery, it has the added complexity of a different approach to public-private *within* continuing care, that is, residential long term care compared to home care. Consequently, the policies for public and private do not vary by region (although there is limited access to alternative private care in rural areas), but rather by program.

The conceptual differentiation of financing and delivery is particularly useful in comparing Nova Scotia's and Alberta's approaches to public and private involvement. A simplified generalization would be that the Alberta system tends to support public financing of private delivery, while Nova Scotia encourages private financing of private delivery. These generalizations are discussed in more detail below.

Financing refers to the extent that services are publicly or privately funded. In Nova Scotia, within residential long term care, the emphasis is on individual or private financing of the publicly regulated system. This is significantly different from Alberta where the public system provides substantial subsidies to the cost of beds in long term care facilities regardless of the individual's ability to pay. The approach to home care services is similar between the provinces in that the assessed nursing care needs are financed by the public system and user fees for home support services enable shared responsibility for financing.

Delivery refers to whether the organizations that deliver services are public or private. While both Alberta and Nova Scotia emphasize private delivery, distinctions between the two provinces arise within the definition of private. Specifically, differences in the involvement of for-profit versus not-for profit organizations are evident. (There is no evidence of differences in the involvement of voluntary organizations or family caregivers in the delivery of care). In Alberta, greater inclusion of for-profit agencies in the delivery of home care services is evident in particular regions while in Nova Scotia not-for-profit agencies deliver most of the care required.

This case analysis has highlighted the differences that exist between two economical and ideological diverse provinces in Canada. These provinces are distinct in their organization, financing and delivery of continuing care services, on the amount of research and policy formulation that has occurred over the past decade, the state of their economies, and in terms of their changing demographic profile. What this analysis has also revealed is that some of the key issues affecting

long term care, the capital expenditures of nursing homes, the delivery of care in rural settings, achieving the best balance of public and private mix in the system . . . continue to challenge government in both jurisdictions.

Irrespective of the jurisdiction under examination, policy makers are still faced with the overriding logic that if for-profit organizations are in the business of delivering care and it is, from the government's perspective, for the purpose of system efficiencies, those savings from the efficiencies are reflected in 'profit margins' for shareholders or owners, which may not be fed back into the system.

The questions then become value-based. Should people derive profit from the delivery of health services? If so, then how much is 'acceptable'? Should government be concerned that foreign multinational corporations are making profits out of the Canadian health care system? Should government fund for-profit organizations in health care, especially if people will pay privately anyway for these services? And if people are willing to pay privately, should we be concerned that government is paying such organizations to deliver services to those who *may not* be able to pay privately?

Because continuing care in Canada is outside the *Canada Health Act*, there is a mix of public and private, for-profit and not-for-profit organizations in the system that have co-existed for a number of years. Anecdotally, however, it appears there is a growing amount of continuing care now being provided outside the public system. Based on the interviews in this case study, it appears that individuals are increasingly paying for more services privately. This reflects both the erosion of services inside the system and the market response to the demographic, fiscal and political imperatives currently characterising the country. How large that shift to the private payment and delivery of care is unknown, but an understanding of the nature and extent of this change is critical if we are to fully understand the requirement for publicly funded continuing care in Canada.

TABLE OF CONTENTS

Acknowledgments	i
Executive Summary	ii
Table of Contents	v
1. INTRODUCTION	1
2. METHODOLOGY	2
3. THEMES IN THE PUBLIC-PRIVATE SPLIT IN CONTINUING CARE: NOVA SCOTIA AND ALBERTA	3
4. LITERATURE	4
5. THE PUBLIC-PRIVATE SPLIT IN NOVA SCOTIA: HOME CARE AND RESIDENTIAL LONG TERM CARE	9
5.1 Context	9
5.2 Residential Long Term Care Program	10
5.2.1 Structure	10
5.2.2 Access	11
5.2.3 Legislation and Regulation of Long Term Care Facilities	12
5.3 Residential Long Term Care Funding	12
5.3.1 Government Funding	12
5.3.2 Individual Funding	13
5.4 Delivery	14
5.4.1 Type of Service	14
5.4.2 Type of Service Provider	14
5.4.3 Incentives and Disincentives for Privatization and Profitization	15
5.5 Home Care in Nova Scotia	16
5.5.1 Structure	16
5.6 Home Care Funding	17
5.6.1 Public Home Care	17
5.6.2 Private Pay Clients	18
5.7 Delivery	18
5.7.1 Type of Services	18
5.7.2 Type of Service Providers	19
5.7.3 Reimbursement of Service Providers	20
5.7.4 Quality of Care	20
5.7.5 Incentives and Disincentives for Privatization and Profitization	20

5.8	Public-Private Mix in Continuing Care in Nova Scotia	21
5.8.1	Delivery of Care	21
5.8.2	Funding	21
5.8.3	Role of Advocacy	22
5.9	Summary	22
6.	THE PUBLIC-PRIVATE SPLIT: ALBERTA’S CONTINUING CARE SECTOR	24
6.1	Context	24
6.2	Continuing Care Structure in Alberta	25
6.3	Financing and Delivery	26
6.4	The Public-Private Mix	29
6.4.1	Issues in the Delivery of Continuing Care	30
6.4.2	Facility-Based Care	32
6.4.3	Facility Care Clients	34
6.4.4	Home Care	35
6.4.5	Home Care Clients	37
6.5	Summary	39
7.	Case Study Summary	41
	Appendix A: Interview Questions	43
	Appendix B: Interview Participants in Nova Scotia	44
	Appendix C: Alberta Organizations That Participated in Interviews	46
	Appendix D: the General Social Survey	47
	References	52

The Public-Private Split in Continuing Care: Case Studies of Nova Scotia and Alberta

1. INTRODUCTION

The purpose of this case study was to examine the nature of the public-private split in continuing care in Nova Scotia and Alberta. This is one of three case studies being conducted as part of the Health Canada study of incentives and disincentives in continuing care in Canada, which also includes a national survey of the continuing care sector. The overall purpose of the Incentives/Disincentives project has been to provide more evidence-based discussion of key issues surrounding various approaches to the funding of continuing care in Canada. The material provided by the entire study will be used to inform our understanding of client care and health benefit objectives, assist providers and clients with further knowledge on the sites of continuing care, and enhance our awareness of the issues surrounding the public/private system of funding continuing care services. The two provinces for this case study were selected because they reflect very different approaches to continuing care, as the following pages will show.

The mix of the public and private sectors in health care is the subject of considerable debate in Canada. The most recent example centers around Alberta's desire to introduce legislation that will allow public funding to be directed to private hospitals to perform in-patient surgeries. To many observers, this represents the beginning of a new era in privatization in health care. It also provides an opportunity to establish the 'ground rules' for such developments in other provinces, where the political will may exist for greater levels of privatization (see Evans et al., 2000).

There is much confusion surrounding the public-private mix, and also much emotion. As the National Forum on Health noted:

"Some argue that the right to establish and use a private market alternative to the publicly funded system is essential in a free and democratic society. People have the right to spend money as they please. Prohibiting or severely penalizing the growth of private market alternatives, it is alleged, discourages innovation and creates a system destined for mediocrity and bureaucratization. "Consumer choice" is the order of the day - the more alternatives are available, the greater the chance of meeting both the needs and wants of people" (National Forum on Health, 1995:13).

At the heart of the issue is the nature and extent of *rationing* - whereby resources are finite, and yet a range of needs and wants by society will exist. The public sector (i.e., government), which governs the supply and distribution of the public's health care resources, makes a public decision about what to fund and what not to fund. For Canadians, the key issue is, "not whether the supply is limited (rationed), but whether the limits are reasonable, affordable, ethical and able to meet the health care needs of the population" (National Forum on Health, 1995:10). To many observers, 'private' typically equates to 'for-profit', but in reality 'private' can have many different meanings stemming from both the payment mechanism and the provision of services (see Evans et al., 2000). Fundamentally, for-profit organizations have a profit motive that is seen as the driver for their

behavior. That then begs the question as to the extent to which savings made through cost efficiencies are then fed back into the care of clients and, therefore, the system as a whole, while still maintaining a level of quality care comparable to that provided through not-for-profit organizations or the public delivery itself.

2. METHODOLOGY

The key informants for the profile of Nova Scotia were selected from the home care and long term care sector and include policy makers service/program deliverers and representatives from advocacy organizations. Attention was given to obtaining respondents from public and private sectors (for-profit and not-for-profit), as well as those representing larger and smaller organizations. One of the difficulties in interviewing a range of service providers is their responses to the equity and appropriateness of the current system are often contingent upon the interests of the group that they represent. *“It is not a level playing field; but, this depends on who you talk to as to whether there is a bias towards for-profit or not-for-profit provision.”*

In Nova Scotia face-to-face interviews were held with 16 individuals and telephone interviews were held with 3 individuals. The interviews were approximately one hour in duration and took place in January and February 2000. A pre-established list of questions guided the interview. The questions are presented in Appendix A, and a list of participants is provided in Appendix B.

The profile of Alberta was based on a series of semi-structured face-to-face and telephone interviews conducted with stakeholders in continuing care in Alberta. These stakeholders came from government, regional health authorities, for-profit and not-for-profit organizations, public agencies and associations. In total, 24 stakeholder organizations were interviewed in February and March 2000 (15 face-to-face and 9 telephone interviews). A list of organizations interviewed for this study is provided in Appendix C. The questions used in Nova Scotia formed the basis for the discussion in Alberta (see Appendix A).

Organizations were contacted by telephone and asked if they would participate in an interview at a later date. They were then faxed an outline of the study and subsequently interviewed either in-person or by telephone. The themes, patterns and issues that emerged in the first phase of interviewing were expanded upon in subsequent interviews. Additional documentation was collected from the interviewees, the provincial government and the data from the national survey.

An analysis of Cycle 11 of the 1996 General Social Survey on Social and Community Support was also conducted in order to understand the extent of usage of public/private agencies compared to hiring paid workers directly. While the interviews with policy makers and agency representatives gives us insight into the public-private mix in home care, one of the key areas is the private contracting of paid workers who are self-employed. The results of the analysis are provided in Appendix D.

3. THEMES IN THE PUBLIC-PRIVATE SPLIT IN CONTINUING CARE: NOVA SCOTIA AND ALBERTA

There are a number of prevailing contextual issues that have some bearing on the nature and extent of continuing care in each of the provinces. The following table outlines some of these dimensions.

Dimensions	Nova Scotia	Alberta
Demographic imperatives	<ul style="list-style-type: none"> - out migration of youth from NS generally and rural areas - increased proportion of seniors in rural areas - limited in-migration from other prov/countries - increased “snowbird” retirees 	<ul style="list-style-type: none"> - influx of population - growing proportion of population seniors
Fiscal imperatives	<ul style="list-style-type: none"> - slow economic growth - provincial budget not yet balanced - moratorium on long term care beds as a way to reduce costs 	<ul style="list-style-type: none"> - economic growth - surplus in budgets - increased privatization in other sectors
Political context	<ul style="list-style-type: none"> - change of Provincial government- conservative elected 1999 - increased emphasis on continuum of care - strong advocacy group for seniors 	<ul style="list-style-type: none"> - long term conservative government - interest in privatization - raising the stakes on health care with federal government
Ideology	<ul style="list-style-type: none"> - individual responsibility for cost of long term residential care - user fees income tested for home support - home nursing services - no user fees - in home care - not-for-profit delivery supported - in long term residential care - all types of providers 	<ul style="list-style-type: none"> - strong interest in shifting costs away from government in continuing care and other sectors of health and social services
Human Resources	<ul style="list-style-type: none"> - limited training standards - very low wages for home support - no regulation of home care industry except for Home Care Nova Scotia clients 	<ul style="list-style-type: none"> - human resources an issue - staff shortages, high turnover - mainly non-unionized - low wages - costs of travel an issue
Context: Evolution and Vision	<ul style="list-style-type: none"> - municipal involvement in continuing care until 1995 - movement towards single entry of long term care and home care - no strategic plan in writing - currently addressing many issues in a short time frame 	<ul style="list-style-type: none"> - increased emphasis on privatization - emphasis on regional models of health care - history of a public-private mix in continuing care
Access	<ul style="list-style-type: none"> - limited competition of home care agencies in rural areas as economies of scale come into play - access to services may be limited - incentives to use home care over long term care - no incentive to save for LTC - all services are same regardless of private pay or publically assisted. 	<ul style="list-style-type: none"> - growing incentives to move care into the community - waiting lists for continuing care facilities - growing interest in having individuals pay for some of costs of care - many individuals paying privately, and numbers increasing

4. LITERATURE¹

Deber et al. (1998) identify levels within 'public' and 'private', whereby public is geographically defined and private is organizationally-based: Public - nation, province or state, region, and local; Private - corporate (for-profit), small business/entrepreneurial, charity/non-profit (paid employees or volunteers), and family or personal. The classification offers some interesting considerations as organizational entities enter into markets beyond their own geographical boundaries.

There are a number of justifications typically put forward for public over private involvement in health care (Deber et al., 1998: 433-435). The advantages include; public goods, externalities, market failure, and the provision of order and social justice. In contrast, inefficiency, lack of innovation and overuse are often cited as reasons for less public involvement.

There is potential for confusion in the public-private debate (Evans et al., 2000). There needs to be distinctions made, for example, between public and private financing, allocation and delivery. Typically, this is expressed as follows:

Financing: whether services are publicly or privately funded.

Delivery: whether organizations that provide the services are public or private.

Allocation: the link between financing and delivery that reflects the degree of government control over the delivery system. Various market forces are used to determine what services are provided, by whom and at what cost (through the use of contracting, for example). Contracting can be used to influence the quality and cost of providing services, improve efficiencies and instill an element of competitiveness amongst private (which includes for-profit and not-for-profit operators) and public providers, such as on the basis of innovative practices (Deber et al., 1998).

Even within the definition of 'delivery' some further clarity is required. Bendick (1989:98) defines privatization as "shifting into non-governmental hands some or all roles in producing a good or service that was once publicly produced or might be publicly produced." Similarly, Starr (1989: 21) defines privatization as "any shift from public to private of the production of goods and services". Bendick (p.98) recommends that government retains some or all responsibility for funding the service while delegating production and delivery, a process referred to as "empowerment of mediating institutions".

Within 'private', Bendick (1989) makes a distinction between 'not-for-profit' and 'for-profit' organizations. Using some empirical evidence from the US, Bendick asserts that for relatively straightforward services that are easily measurable and evaluated, the use of for-profit organizations

¹ This section relies significantly on a report by one of the authors - Keefe (1999) Human Resources in Home Care: Comparative Analysis of Employment Arrangements. Prepared for Knowledge and Dissemination Division, Health Canada, 120 pp.

would seem appropriate. In contrast, when services were more "complex, undefinable, long range and subjective", the effectiveness of the for-profits diminished. Not-for-profit organizations, he claims, provide better services to clients than for-profits when services required often fall outside the specific contractual commitment.

Public and private sectors differ in many ways. The relationship of public and private agencies to the provision and production of services needs to be understood in the context of home care. In service provision, the government must decide first whether and who should be provided the services and how much is needed; second, they must arrange for the recipient not to pay directly; and, third, they must decide who will be the producer of the services (Kronenfeld & Whicker, 1990). In some cases, the public sector may be both a provider of a service, and also be a producer of that service in the public sector. Contracting out with a private agency is another approach, and one that is gaining increased attention in Canadian home care.

Contracting out is a form of privatization. The definition of privatization, however, varies depending upon the nation state in which it is used (Kronenfeld & Whickler, 1990). In Britain (and in Canada for that matter) privatization may mean the selling off of state interests to a private company (e.g., in Canada the privatization of Petro Canada) or it may refer to the public welfare state contracting out to private agencies to deliver services rather than providing it directly themselves (Bergthold, Estes & Villanueva, 1988).

Definitions of different employer types are needed, as some literature refers to the private sector as solely including the for-profit industry (OHHCPA, 1999). The public sector, they argue, should include not-for-profit organizations because they obtain significant public funding. More commonly though, three categories can be used to differentiate between public and private, and to further categorize within private as including the tax status definition of for-profit versus not-for-profit. The confusion occurs because the not-for-profits share some characteristics of both proprietary and public agencies - "[they] share the characteristics of being in the private sector with for-profit firms, [and] they share an orientation toward broader community service with government agencies" (Kronenfeld & Whicker, 1990, p.21). For this case study, the public sector is defined as services that are delivered by public sector (government) employees. Private sector includes both agencies whose tax status is for-profit (FP) and those not-for-profit (NFP) agencies whose tax status is charitable.

Canadian policy initiatives have encouraged the increased role of privatization in health care services and this phenomenon has been discussed elsewhere (Fuller, 1998; OHHCPA, 1999). The privatization of the Canadian health care system is a very sensitive topic in a country with universal health care, despite the argument that portions of our health care system are driven by the private sector, and that much of continuing care has traditionally been provided through a combination of FP and NFP organizations because such care is outside the Canada Health Act. (Indeed, there is often little commentary of the (private/public) split in continuing care in the research literature related to the public and private elements of health care - see, for example, Drache and Sullivan (1999).

In British Columbia there are currently few differences between for-profit and not-for-profit in hourly wages for home support workers (Hollander, 1994). In the early 1990s research indicated that the wage differential between FP and NFP was the underlying cause of high staff turnover in FP agencies. Differences in turnover rates by type of employer were also reported in long term care facilities. In a US study that examined the turnover rates of aides across nursing homes, the authors report that FP homes had a 1.7 times higher turnover rate than did NFP facilities (Banaszak-Holl & Hines, 1996). Predictors of the turnover rate included the aide involvement in care planning (though not in assessment), and local economic factors such as the number of nursing home beds available, the unemployment rate and the per capita income (Banaszak-Holl & Hines, 1996).

In response to a perceived threat of privatization of the home support component of home care in Manitoba in 1996, Shapiro (1997) reports that the turnover rate of unionized home support workers was as low as 15% in Manitoba where the workers are employed directly by the provincial home care program (Shapiro, 1997). She argues that the effect of privatization would be to increase turnover in the home care sector. While it may be true that proprietary agencies are more likely to pay lower wages, caution should be exercised when comparing across provinces because of the differences in economic context. The low unemployment rates in BC in the 1990's, in comparison to Manitoba, may have affected these high turnover rates. As Banaszak-Holl and Hines (1996) found in their research on nursing home aides, the local economic context has a significant impact on the turnover rates.

Traditional distinctions between for-profit and not-for-profit organizations in the delivery of home health services have been observed in the American context. These include: for-profits tend to favor insured services that can be reimbursed, while not-for-profits perform more uninsured services like homemaking; not-for-profits will serve more low income and minority clients, focusing more on 'need' rather than profit, unlike for-profit agencies; for-profits will hire more technically trained staff to conduct their more medicalized services compared to not-for-profits; not-for-profits will be more dependent on government revenue for support than for-profit agencies; and for-profit agencies will receive more income from Medicare, insurance, and co-payments due to their delivery of more medicalized services compared to not-for-profit agencies (Clarke & Estes, 1992).

Clarke and Estes (1992) examined the effects of privatization (i.e., the increase in for-profit agencies) and rationalization (increase in chains and integration of agencies) on the occurrence of isomorphism (homogenization of agencies due to exposure to similar conditions) between for-profits and not-for-profits in the areas of service provision, client mix, contracting, staffing, and sources of revenue. For-profits and not-for-profits only differ in a few areas. For example, for-profits are 17% more likely to have homemaker services than not-for-profits. The reason for this is for-profits have aggressively marketed this service to the public, and they have lower overhead costs than not-for-profits. Another example is that not-for-profits serve more clients per month than for-profits. The reason for this is not-for-profits are made up of more older and established institutions than newer for-profit agencies. Also, for-profits tend to have larger staffs (on average 45 more employees) than not-for-profits (Clarke & Estes, 1992).

However, when they controlled for scope of the organization, that is, whether the organization was part of a larger chain or a smaller non-chain agency, findings suggest that isomorphism appears to occur among large chain organizations. In other words, for-profit system members tend to be like not-for-profit system members. It could be that since home health care agencies are usually larger than non-chains and there are fewer of them around, it is easier to monitor one another regardless of their FP or NFP status (Clarke & Estes, 1992). Hence, if exposed to similar forces, they are likely to become similar in nature to one another (e.g., in terms of their practices and organization). In the area of access to care, the NFP agencies have evolved by adopting FP practices and structure (Clarke & Estes, 1992; Estes & Swan, 1994), but again variations of these changes do not occur equally among agencies with a different scope of operation.

Macro level changes which occurred in the US home health care industry were an outcome of government policy. The historical analysis of the effects of this restructuring on the organization of home health care provides some insight into potential directions for the future of home care in our country. American studies have indicated that context and restructuring was not necessarily a good thing for either the workers, who were more likely to be contracted out, working part-time and for low wages, or the home care recipients, especially those who were unable to pay privately. Another important change was the increased medicalization of services, because it was for these services that the government was willing to pay. Many of these processes have already begun to develop across Canada (Anderson and Parent, 1999).

In the Israeli context, Schmid and Sabbagh (1991) report that NFP agencies invest more in the management of human resources, particularly in the areas of training and development, working conditions, job security and in providing additional perks, compared to FP agencies. They examined the performance of workers and the organizational efficiency from the perspective of the client. Clients gave home care workers in NFP agencies a higher satisfaction and evaluation ranking than home care workers in for-profit agencies; however, no differences were reported in terms of organizational efficiency or with client satisfaction with organizational performance (Schmid and Sabbagh, 1991).

From a sample of 82 workers in the home care industry in Israel, Schmid (1993b) reports that from the perspective of the workers, working conditions were better in NFP organizations than FP organizations. She measured the number of fringe benefits (such as sick leave, vacation time, pension plan and severance package), other benefits (including economic aid and social and cultural activities), and additional rewards or perks (such as bonuses or letters of appreciation). In each of these areas, NFPs provided more benefits and rewards.

Workers in large FP agencies reported greater levels of empowerment than those in smaller FPs or NFP agencies. However, this increased empowerment was not viewed by the author in a positive light. She concluded that issues of control and supervision of the workers--issues associated with quality of care--were tighter in NFP compared with large or small FP agencies (Schmid, 1993a, p.144). Worker perceptions of organizational fairness, in terms of fair wages and fair working conditions were also analyzed by type of employer. Here again, the workers in the NFP agencies

rated organizational fairness higher than did workers in small and large FP agencies, although the level of fairness over all types of organization was low.

The findings from Schmid's research suggests that, at least in Israel, the organizational behavior of not-for-profit providers has relative advantages over the behavior of for-profit providers. "Not-for-profits invest themselves more in the management of their human resources, offering training programs and working conditions that scarcely exist among for-profit providers" (Schmid, 1993a, p. 144).

Summary

Some general observations from the literature inform this case study. First, it appears that in order to survive in an increasingly competitive market, NFP providers of home health services may take on the characteristics of FP providers. Second, that chain or system membership is more likely to adhere to the process of isomorphism, in that FPs and NFP chains begin to look alike while the difference between FPs and NFPs remain among the non-chain enterprises. Third, that some characteristics, such as the increased medicalization of formal home care services, have already begun in Canada with the increased emphasis on home care as a mode of acute care substitution and the decreased emphasis on maintenance or preventative care (see also Parent, Anderson, Keresztes and Arnold, 2000). Fourth, the traditional differences among FPs and NFPs have been in the human resource issues affecting the workers (FP with less pay, fewer benefits, lower unionization). There is a perception that FPs are more interested in consumer control and are more cost effective--particularly in areas of administration.

An increase in the use of privately funded alternatives, difficulty with staffing the public system, and waiting lists are indicators of the shift of patients and providers to a privately funded continuing care sector (Deber et al., 1998). The active or passive withdrawal and restriction by government to publicly funded services has created fertile ground for active growth in the private sector to meet consumer demands. The notion of a stronger presence of the private sector is no longer seen as out of the realm of possible policy options to address a health care system in crisis. Of concern to many observers is not so much the level of privatization, but the growing level of 'profitization' in the health care system. (e.g., Fuller, 1998).

Another key dimension to the public-private split in the Canadian context is the provision of services in the community. As these services mostly fall outside of the Canada Health Act, and provinces therefore can direct policy according to how they see appropriate, there can be a combination of public and private (for-profit and not-for-profit) involvement. Indeed, there is growing *speculation* that more for-profit involvement in continuing care will have a negative effect on the system and the care of clients. There are then, a number of angles one can take when slicing the many dimensions of public and private care. More appropriately perhaps, the key issue is more along the lines of what the National Advisory Council on Aging contends, namely:

"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" (NACA, 1997).

5. THE PUBLIC-PRIVATE SPLIT IN NOVA SCOTIA: HOME CARE AND RESIDENTIAL LONG TERM CARE

5.1 Context

Nova Scotia has one of the highest proportions of elderly persons in their population. In 1999, 13.2% of the population were aged 65 and older compared to the Canadian average of 12.4%. The Nova Scotia Department of Community Services (DCS) has a long history of providing comprehensive long term care residential services to residents who are elderly and mentally or physically disabled. Various types of long term facilities were built in the mid 1970's and the funding was shared between the provincial and municipal governments, while the administration was provided by the 66 municipal units.

A province-wide Coordinated Home Care Program was initiated in Nova Scotia in 1988, which was limited to persons aged 65 and older. Its services consisted of nursing and home support, which were targeted towards persons who needed chronic home care. The administration was split between the Departments of Health and Community Services. In 1995, a revamped province-wide home care program, namely, Home Care Nova Scotia, was introduced. This program is under the jurisdiction of the Department of Health (DOH) and its mandate is to provide acute home care, in addition to the already established chronic care program.

Therefore, prior to the mid 1990's, both home care and residential long term care (consisting of a variety of licensed facilities providing various levels of care) were under the jurisdiction of the DCS. In 1993, the administrative responsibility for Coordinated Home Care, homes for the aged, and nursing homes were transferred from the DCS to the DOH. The other types of licensed facilities - group homes, residential care facilities, adult residential care facilities, and regional rehabilitation centres remained under the DCS. These latter facilities provide care to physically and mentally disabled persons, while nursing homes and homes for the aged predominantly provide care to seniors. By the end of 1998, the administration of residential long term care was centralized to the DCS as municipal care coordinators, who had been administering these programs, became provincial DCS employees. On April 1, 2000, other types of licensed and community- based options, which house seniors, were expected to be transferred to DOH. The care coordinators who assess and case manage seniors will also be moved to DOH.

As of March 2000, responsibility for neither long term care nor home care has been devolved to regional health authorities. Funding and policy directions for home care (known as Home Care Nova Scotia) and residential long term care are managed by two Program Directors who report to the same Executive Director at the Department of Health, under the Division of Community Care. This arrangement has led to distinct policies for these two critical components of the "continuing

care” system and, interestingly, the term “continuing care” is not used in Nova Scotia. Consequently, long term care typically refers to facility-based care and home care describes various services and supports provided to individuals in the community.

The planning and policy development for residential long term care is fragmented, given the division of responsibilities between Health and Community Services for various types of facilities. From an administrative perspective, program planning and development is further complicated by the fact that up until April 2000, the “eligibility” components of both home care (such as the In-home Support program) and long term care (funded by the Department of Health) are administered in the Department of Community Services.

Over the years, there have been numerous discussions about the need for a single point of entry. Currently, there is a plan to introduce a single point of entry by April 2001. However, until this one stop approach is implemented, access to residential long term care and home care continue to be splintered. For example, if one requires a nursing home, contact is made through the DCS District office, located in four regions under the Department of Community Services, while if home care is required, contact is made through one of the Home Care Nova Scotia regional offices, which have been decentralized.

5.2 Residential Long Term Care Program

5.2.1 Structure

The Homes for Special Care Act was proclaimed in 1976 and is the legislation and regulatory framework under which the various types of homes for special care are funded and regulated/licensed. These facilities include: nursing homes and homes for the aged, funded by the DOH and group homes, residential care facilities, adult residential care facilities, and regional rehabilitation centres and the DCS. Any operator of a residential long term care facility, where care is provided for at least three or more unrelated persons, must first obtain approval from the Minister of Health or Community Services prior to constructing the home. Once they are constructed these facilities are inspected and licensed on a yearly basis.

Initially, all Homes for Special Care (HFSC) were licensed and regulated by the DCS, while the 66 municipalities administered (i.e., determined eligibility for financial assistance/subsidization and for care), and partially funded individuals in need of residential long term care. In addition, approval to admit a client involved an additional layer of bureaucracy as care coordinators obtained from the DCS. However, once approved, the home retains the right to decide whether or not they will accept the client. By 1998, the government transferred both the administration and the staff from the municipalities to the DCS.

Currently, HFSC planning, regulation, management, funding, and policy is split between two departments - the DOH and the DCS. This is further complicated by the fact that, even within long term care facilities funded by health (nursing homes and homes for the aged), the DOH pays for

individual costs, but the DCS care coordinators assess clients for eligibility in relation to financial subsidy and care needs. As of April 1, 2000, these staff were expected to become DOH staff. In addition to the assessment conducted by the care coordinators, a medical form signed by a physician is required.

5.2.2 Access

“A single point of entry is currently not in place, but once it’s implemented providers will lose control over the type of client they admit; there will be an outcry regarding loss of autonomy.”

Currently, the absence of a single entry system limits appropriate utilization of resources, as individuals with the ability to pay privately can “*buy their way into a nursing home*”, since no assessment of care need is required prior to admission. Therefore, Nova Scotia’s residential long term care program can be characterized as a two tier program, consisting of incentives for both clients and providers. For example, clients with money who have the ability to pay privately can gain quicker access to a long term care bed (i.e., jump the queue). Moreover, providers have autonomy (i.e., the freedom to accept or reject a client), which enables them to admit a client who needs the lowest level of care (i.e., “cherry picking”). As a result of this two tier system, Nova Scotians can gain direct entry or admission to a nursing home, as long as an individual can guarantee they have 18 months of income and assets, which will be used to pay for care.

“The NS system is eligibility-based; determination of how care is to be paid for [i.e., assessing whether the client will be publicly subsidized based on the extent of an individual’s assets] is entangled with assessing need for care and, therefore, determination of financial eligibility precedes care needs.”

As this quote illustrates, one of the consequences of having a two tiered residential long term care system is that determination of financial eligibility precedes determination of need for care. Therefore, individuals with the ability to pay privately can circumvent the assessment by DCS care coordinators, where the purpose is to determine both eligibility for care and eligibility for financial subsidy.

In addition to the issues regarding differential access to facility based care, the administrative costs to the government and inconsistencies in the ways in which policies are interpreted emerged in one interview. *“The administration of financial means test is time consuming, e.g., bank checks to verify income and track whether assets were divested within the last three years, discussions with family, dealing with non-designated residences and second properties, as well as splitting income and assets if a spouse remains at home, etc.”* Moreover, a participant stated, *“There is an equity issue from the client’s perspective because care coordinators interpret the policies differently and accountability for decision-making is problematic, given the care coordinators work for DCS and administering the program on behalf of the DOH.”* This later issue was identified by the Auditor

General's Report 1996-1997, which suggested that current practices range from extensive detailing of bank records and income tax returns to limited verification of income and assets.

There are also several types of residential long term care service options that have evolved over the last 10 years. One example is the development of small option homes, where up to three unrelated persons receive long term care. These small option homes are unregulated, but there are provincial standards developed by the Department of Community Services, which for-profit and not-for-profit providers must adhere to. Small option homes were developed in response to "market demand". That is, they were first created in response to the de-institutionalization movement where mentally ill and mentally challenged individuals were repatriated to smaller community settings. Since their inception, however, they also evolved in response to a shortage of nursing home beds in rural Nova Scotia. There are approximately 321 small option homes in Nova Scotia, most of which are for-profit facilities.

Assisted living facilities are another form of residential long term care that continue to evolve. These are delivered primarily by private, for-profit providers. These facilities are modeled after the quasi-independent units that often form part of a care continuum and again, they are not regulated through licensing. The premise under which these facilities operate is the client requires minimal care but is purchasing services, such as meal preparation, care of personal living space, laundry, etc.

5.2.3 Legislation and Regulation of Long Term Care Facilities

Facilities that fall outside the Homes for Special Care Act have implications for people with the resources to purchase long term care services privately. Given that assisted living facilities are not required to meet any type of provincial regulations or be licensed in order to provide services, while small option homes have guidelines (but no legislative clout), the state appears to have shrugged off any responsibility for quality and the market forces prevail. It is concluded that the role of the state, in relation to privately purchased long term care services, is unclear and some participants thought there should be safeguards in place; while others thought reputation and the facility's ability to maintain this is all that is required.

5.3 **Residential Long Term Care Funding**

5.3.1 Government Funding

Each facility must submit a yearly budget to either the Department of Health or Community Services and, upon review, the department sets a per diem rate for publicly subsidized clients. These rates are based on a funding formula for nursing care, capital expenses, and historical program expenses. Within this approach, "*there is a built-in profit margin in the determination of per diem rates for profit providers.*" Questions were raised about the need to develop rules about regulating the areas where the for-profit sector can make a profit. However, it is important to point out that as

one respondent indicated, *“both for-profit and not-for-profit providers are able to keep savings generated through efficiencies.”*

Because of the type of funding formula used, there is limited standardization of per diem rates. Moreover, most facilities have a blended per diem where the same rate is paid irrespective of whether the client requires Level 1 or Level 2 care, while other facilities, about 10 out of 70 nursing homes, have two different per diem rates - one for Level 1 care and another for Level 2 care. Blended rates may have the consequence of gaming or “cherry picking” for the lowest level client. Those interviewed outlined this type of approach provided as an, *“incentive to take lower care residents but that single entry will have a big impact on changing this practice where providers have the ability to cherry pick residents.”*

Because there is no formal regulation/protection of the per diem amount charged to private paying clients, some homes may charge a higher rate than what the government has agreed to pay for a publicly funded client.

5.3.2 Individual Funding (Per diem differential for private pay clients)

It is important to point out that in the Nova Scotia system, *“private pay and publicly assisted residents are not treated differently in the home.”* As one respondent explained, the only incentive to be a private pay client is the privilege of “jumping the queue” to obtain access to care without completing an assessment. *“There is no difference once the client is admitted to care; but the entry point gives preference to those who can pay privately.”* Taken to another level, “jumping the queue” at the entry level may have an impact on other programs, such as home care. As one respondent noted, *“Private paying clients “may” be admitted to a nursing home before a publicly subsidized client and this practice impacts on home care resource utilization.”*

“Nova Scotia has a pay as you go residential long term care system; every asset and regularly occurring income is considered (except GST refund) when determining what assets the client can put towards the cost of their care, although the designated or primary residence is excepted.”

As a result, one participant observed that within the Nova Scotia system, *“There is no cap on the individual’s contribution level.”* Currently about 20% of long term care residents are private paying, but there is no data on the length of time an individual remains private pay. For example, do private paying individuals have sufficient resources upon admission to pay for nursing home care or at what point must the state intervene with subsidizing the difference between their monthly income and the cost of care once assets have been depleted? Another stated, *“Private pay residents do not receive anything different than publicly subsidized; so there is no incentive for anyone to save assets to pay for nursing home care because even if the client has no money, they are not refused admission if the care is needed.”* Put another way, participants said, *“There is no incentive to preserve assets to pay for long term care services because the level of service is the same for both*

private pay and publicly funded residents; the private paying resident may get a private room, but, probably not given the current availability.”

5.4 Delivery

5.4.1 Type of Service

Within the long term care system, there have been few licences granted for nursing homes or homes for the aged beds over the past five years. Indeed as one respondent put it, *“There has been limited expansion of province-wide bed capacity by either for-profit or not-for-profit provider.”*

However, *“There has been growth in “small option homes” that provide care to three unrelated people.”* There has also been growth in for-profit assisted living facilities. Respondents estimated that about 400 spaces have been developed in the Central Region. Another suggested that, *“A future pressure point for both home care and residential long term care is the demand created by those who have moved into assisted living and who eventually will require services beyond the capacity of free standing assisted living facilities.”* Since some have been built as an “add on” to existing nursing homes, there is the ability to move clients to a higher level of care. Nonetheless, it is observed that all the growth appears to have been in residential services provided by for-profit providers and that these facilities or residences are unlicensed and have minimal or limited regulations.

In the not-for-profit sector, there has been an increase in the number of not-for-profit enriched housing units. Enriched housing units are attached to long term care facilities and clients can purchase services according to their needs from the facility. This increased development raises an issue about the interface of enriched housing with other services, such as home care, within the continuum of care. Interestingly, the cost of services purchased by residents in enriched housing exceeds the fee for service charged by Home Care Nova Scotia (HCNS) for home supports for clients receiving the maximum amount of services who have the maximum income.

5.4.2 Type of Service Provider

Facilities are operated by not-for-profit organizations, municipal corporations, and for-profit firms. The provincial breakdown is: 20 are owned by for-profit providers, representing about 1/3 of the bed capacity; 24 are operated by not-for-profit providers; and 23 are municipally owned and operated facilities. Within both long term care and home care, the provincial government does not have explicit policy on the role of for-profit and not-for-profit service providers. As one respondent stated, *“It is not a level playing field; but, this depends on who you talk to as to whether there is a bias towards for-profit or not-for-profit provision; government need[s] to consider the role of for-profit and not-for-profit providers in the provision of health care - a policy decision is needed.”*

There is disagreement regarding the impact of the status of the provider on the quality of care. Some said that the status of the provider does not compromise quality, while others indicated that quality is an issue when for-profit providers are involved. Annual licensing by both DCS and DOH

provides a safeguard for quality because facilities are monitored. In addition, some facilities, about one third, have chosen to obtain accreditation through the Canadian Council of Health Services Accreditation.

Examples of the disagreement among the respondents ranged from the recognition that “*there is a prevailing view that if the nursing home is run for-profit the care is not as good as that which is provided by not-for-profit providers, and this view is increasing,*” to the response that “*for-profit providers are stigmatized. You must give bad care if you are making a profit.*” At a more fundamental level, the debate centers on how does the FP sector create efficiencies to create profit and how comfortable is the government with the provision of services by FP providers? “*We are moving closer to the debate on whether we should have for-profit nursing homes; the issue is making money at the expense of something; what is deficient in care that accounts for making a profit?*”

5.4.3 Incentives and Disincentives for Privatization and Profitization

We use the term profitization to refer to the increased involvement of for-profit agencies/providers in the delivery of services and the term privatization to refer to the increased involvement of individual residents/clients in paying for the services.

Within residential care, generally there is an increase in the number of providers entering into residential arrangements outside of the current long term care system, for example, in assisted living arrangements. The incentive for this increased profitization is that there are no regulations or licensing of assisted living, congregated settings or small options homes (three or less persons receiving care).

Within licensed care facilities, there are two incentives for increased “profitization” in residential long term care (meaning a bigger role for FP providers) in Nova Scotia. First, a 10% profit margin for FP providers of long term care is currently provided in their budget. Moreover, with FP, the interest and depreciation costs are included as part of cost in per diem rates.

The only disincentive for profitization, although it also applies to NFP, is that any operator must obtain approval for a license (whether NFP or FP) from the Minister of Health. There has been a moratorium placed on licensing additional beds within the past four years.

Another trend in long term care in Nova Scotia are incentives for increased privatization in Residential Long Term Care (meaning an increased role of individuals in the payment of services). At the individual level of involvement, in contributing privately towards the pay of care, two incentives exist. First, in the absence of a single entry model, individuals are able to “jump the queue” and have access to long term care directly, if they have the money. Long term care beds can be purchased by individuals who have sufficient income without having to undergo an assessment.

Second, a blended per diem rate encourages facilities to accept clients with the lowest care needs, as they retain the right to refuse who enters the facility. The DOH is currently reviewing its policy of blended rates and considering the possibility of moving to a case mix approach to funding.

Disincentives also exist in Nova Scotia for the increased privatization. Once the private-pay resident is in the long term care facility, they are not treated any differently than the publically-assisted residents. (In some cases the private pay obtain private rooms but not necessarily.) More accurately, a disincentive to be private-paying exists in that, since the knowledge of using assets (excluding the family home) to pay for the cost of care exists, why save money to pay for long term care when the government will pay for the subsidized cost.

5.5 Home Care in Nova Scotia

5.5.1 Structure

Public home care is predominately funded through Home Care Nova Scotia Division of the Department of Health (DOH) with the exception of services to children who have physical and mental disabilities who are funded by the Department of Community Services (DCS). In addition, some specialized pediatric home care is funded by the IWK-Grace Health Care Centre. Within the HCNS Division, there are three programs: Chronic Home Care, Acute Home Care and In-Home Supports. The latter is funded by the DOH but administered by DCS care coordinators. This will change on April 1, 2000, when a significant transfer is made to Health Care.

Home Care Nova Scotia continues to be administered and funded at the provincial level, although its organization mirrors that of the Regional Health Boards, presumably to enable devolution of responsibility in the future. Consequently, there are four home care regions (Central, Western, Eastern and Northern). Regional Health Care Boards are currently under review to create changes in boundaries as a consequence of an election platform. It is unclear whether the regions within HCNS will follow suit.

Legislation in this area consists of the *Homemakers Services Act* in 1981 and the *Coordinated Home Care Act* in 1990. Agencies and firms/home care providers are not required to meet any type of provincial regulations or be licensed in order to provide services. This is a critical issue raised by a number of the persons interviewed, in terms of the government's responsibility to protect its citizens through regulation. While agencies that are contracted to deliver services to HCNS clients are required to meet quality assurance standards, this is not true for private pay clients. It is "buyer beware" for those persons who access services directly. The client does not know the level of standards and does not realize that the for-profit agencies do not have to meet government standards to open. In other words, "*They do not know the risks involved.*" As another informant exclaimed, "*In Nova Scotia, we have more regulations on hairdressers than we do for home care agencies.*"

5.6 Home Care Funding

5.6.1 Public Home Care

Within the area of funding, there are three dimensions to consider: funding schemes within the Public Home Care Program (including a mix of public and private), private home care services purchased by the individual directly (either to augment services provided by HCNS or outside the public system), or private home care purchased by a third party payer (such as an insurance company).

Within the Public Acute Care segment of home care there are no user fees. The maximum allowable under this program is \$4000 per month. With the Chronic Home Care Program, there are no user fees for nursing services (access is based on care needs only, clients are not income tested). In contrast, home support services are potentially subject to a user fee following an income test. No user fees are applied if income is less than \$14,000. The user fees are \$6 per hour to a maximum of \$360/month. Proposed increases to these user fees were included in the provinces budget, April 2000. If approved the user fees would be \$8 an hour to a maximum of \$400 a month. The program will provide the cost of services to a client up to a maximum of the cost in a long term care facility (about \$2200 a month).

Because the user fees are applied to the lower level of service (e.g., home support and not nursing), there may be a disincentive to use lower cost services. This is particularly evident when a client changes from acute home care to chronic home care. *“User fees become an issue when a client moves from one level of care provider to another or moves from acute home care, with nursing for personal care, to chronic home care, with home support for personal care; there are no fees for nursing care, but there are user fees for home support services.”*

There are other positive and negative attributes identified with user fees. Some clients feel proud to contribute, but for others it is a burden. For low income clients who do not pay user fees, the client may want more services than they need or there may be a decreased likelihood to cancel the service if not needed. *“User fees may be a deterrent to clients’ use of services; therefore, user fees can be a way of decreasing utilization but one needs to understand the ramifications (i.e., if any harm will result as a result of these fees).”*

In the broader continuum of care, user fees raise the issue of equity within continuing care in comparison to hospital care. One respondent suggested that, *“People with substantial assets should pay user fees; the issue is the imbalance between hospital care (which is insured) and home care and nursing home care (which is based on user pay) will lead to continued pressure on the hospital system.”*

The In-Home Support program establishes financial eligibility, using a budget deficit approach, and there is flexibility in types of services and how these are provided (in some cases families are paid to provide care or agencies are used to provide care).

5.6.2 Private Pay Clients

One of the key issues within home care is the involvement of private pay clients. The client has no choice of provider through publicly funded home care (HCNS). However, home care clients are able to augment home care services allocated by the HCNS program by contracting with the home care agency individually. Consequently, as one respondent suggests . . . *“if clients can pay they can receive better service because they can buy more/extra hours of service above what HCNS can provide. We are creating two levels of home care - those with money or insurance can get quicker response and more services.”* This also affects choice. NFP rates are significantly higher than FP agencies. Consequently, clients who are augmenting services tend to do so with FP agencies and HCNS facilitates this process by also contracting their services (at least in the Central region) with the same provider for consistency of care. This may raise a confusion if one worker is partially funded by the public system for certain tasks and funded privately by the client for additional tasks.

In addition, the person in need of care does not necessarily have to go through the home care program to access services. Private pay clients purchase home care services in the marketplace. The options are greater if a client has the resources to pay privately, as generally clients within the HCNS program do not have a choice of vendor. If a client chooses to buy more hours or types of services in addition to those covered by HCNS, then this is an advantage for a client who has the resources to pay privately.

There is confusion among public citizens regarding their role in funding home care services. *“What should I pay for? What is covered by government?”* This confusion suggests the need to educate the public on home care services. Indeed, how to access home care continues to be an issue. Some respondents suggested that, *“It’s not customer friendly; we have done a terrible job as a province of making it easy for people to access publicly funded home care services.”*

To fuel this confusion, one key issue outlined by many informants was, *“Who is the payer of last resort?”* On the one hand, HCNS policy suggests that wherever possible the client’s coverage through private health insurance is used prior to receiving eligible services through HCNS. The insurance companies, on the other hand, are developing a policy position where they regard themselves as the payer of last resort. As one spokesperson states, *“A battle is evolving between third party insurance and publicly funded home care programs. The insurance companies see themselves as a supplement to publicly funded home care. The issue is ‘who is the payer of last resort’?”*

5.7 Delivery

5.7.1 Type of Services

Within the Home Care Program, nursing services are delivered by either the Victorian Order of Nurses (VON) (NFP) or the DOH (public). Nursing Services are public (20-25%) and not-for-

profit (75-80%) delivery. The public - NFP mix in the delivery of nursing services, breaks down geographically. Public delivery occurs primarily by DOH nurses in the rural areas where VON do not have an office; and the delivery of not-for-profit agencies (VON) are primarily in urban centers and surrounding areas.

In comparison, home support within the HCNS program is non-public and mostly delivered by NFP agencies. Home support and personal care services are delivered through a contractual arrangement between the DOH and the home support agency; the agency receives a yearly global budget that is capped in relation to how much client service they can provide; the same fee for service is paid to home support and nursing providers, irrespective of whether they operate in an urban or rural locations or are publicly funded.

There are no FP providers delivering nursing services in the public home care system; however, FP providers deliver “overflow” home support services in the Central Region. Only in this region does the public HCNS *look to for-profit providers to complement/augment the publicly funded system*. Issues associated with this mode of delivery will be discussed in detail under type of providers.

5.7.2 Type of Service Providers

DOH appears to favor not-for-profit home support agencies as the deliverer of home care services and contracts most of their services through them. This support for NFP agencies, while without explicit public policy, affects the development of the FP market. In two exceptions HCNS contracts with FP agencies: the home oxygen program within HCNS contracts with FP providers and in the Central Region when the NFP agencies are unable to meet the service demand, HCNS contract overflow services through the FP agencies. Recently, attempts have been made to limit the usage of FP agencies within the Central Region. For example, *“the centralized dispatch system implemented in Central Region has created efficiencies and reduced the use of for-profit agencies for overflow.”*

There is a growing realization that home care is a market to target, and there is a growth of smaller FP agencies, which appears to be more common in urban NS, but is not limited to urban areas. No multinational, larger, FP providers have expanded into rural areas of NS; but smaller, independent firms have evolved over the last few years. Indeed, FP agencies are flourishing in privately funded home care. More specifically, these changes need to be recognized in their rural and urban context. *“For-profit providers are flourishing within the privately funded home care system in the urban areas, but there are limitations which are prohibiting their extension into rural NS, for example, transportation costs and other costs of delivering services in wide geographic area.”* There is increased pressure on governments to think about the implications of having both FP and NFP providers delivering an essential health service.

5.7.3 Reimbursement of Service Providers

The contracted FP providers in the Central Region do not receive the same rate of compensation as the contracted NFP agencies. *“The for-profit agencies, who are the overflow home support agencies, are paid a fee for service by government, which is lower than what is paid to not-for-profit agencies for the same type of services.”* Moreover, some respondents suggested that *“not-for-profit agencies are getting a lot of help from the government . Services that HCNS accesses differ, depending on whether a for-profit or not-for-profit provider is used; e.g. not-for-profit agencies are used when HCNS prescribes tasks, while for-profit agencies do everything, so when extra hours are being purchased by a client, often the for-profit agency is used”*.

There is disagreement over the cost-benefit of the delivery method, whereby HCNS primarily uses NFP agencies. As one stakeholder put it, *“Not-for-profit providers have a different mentality. For instance they believe that government funds are endless; for-profit providers have an increased awareness of what things cost. Being for-profit forces you to be conscious of cost”*.

On the other hand, others would argue that the de-listing of services and service cutbacks (e.g. foot care, home support tasks such as cleaning, shopping and meal preparation) has resulted in lost business for NFP agencies and has forced clients to use their own resources. *“Clients go without these because they can’t afford or won’t pay the nursing cost for the injection; therefore, user fees can be a deterrent to obtaining care.”* When clients do pay for such services, it is the FP agencies and not the NFP agencies who are getting the business since FP agencies charge less for their services.

5.7.4 Quality of Care

There is disagreement regarding the impact of status of provider on quality of care. Some respondents said that the status of provider does not compromise quality in that *“competitiveness drives for-profit agencies to provide better service”* while others indicated that quality is an issue when FP agencies are involved. *“[It is] difficult for the public to assess standards and quality of services; there are challenges to choosing a service provider.”* HCNS provides a safeguard for quality because agencies are monitored”. However, these agencies are only the ones which service HCNS clients.

5.7.5 Incentives and Disincentives for Privatization and Profitization

HCNS provides incentives for individuals to use the publicly funded system in that all nursing services are provided at no cost to the client. User fees are applied to home support services. These fees are income-tested and provided on a sliding scale.

NFP agencies appear to be the venter of choice by HCNS, while FP agencies are only contracted in specific circumstances. An additional disincentive for FP agencies is that they are paid

at a lower rate than NFP agencies. Moreover, access to any choice of vender is generally limited to urban centers.

Incentives for FP agencies include no regulation or licensing by government departments. Unless the home care agencies are providing services to HCNS clients, no regulations or standards need to be met. Within Nova Scotia, an increasing trend among NFP home support and nursing agencies is to merge into a larger agency, in order to create better administrative efficiencies.

5.8 Public-Private Mix in Continuing Care in Nova Scotia

5.8.1 Delivery of Care

Incongruencies exist in the supportiveness of FP and NFP service providers. With the HCNS program, the government appears to support the role of NFP agencies and only includes FP agencies for very specific contracted services (home oxygen) or in an overflow situation (after NFP have been accessed). Within long term care facilities one-third of the beds are FP and their profit margins are recognized as part of the budget. The allowance for-profit margins for FP agencies is currently under review, as is the government's role in capital expenditures.² Respondents questioned the responsibility of DOH to "*deal with capital funding*", including renovations of existing homes and the development of new facilities.

In home care, the nursing costs are covered by the government, while the nursing costs in long term care facilities are seen as an individual responsibility.

5.8.2 Funding

Government favors user fees in home care as a deterrent to over-utilization; but there is no implications for accessing the service because the low income population are not charged user fees. These policies are currently under review and there is some indication that increased privatization (in terms of individual contributions) may be occurring, although there is no indication that increased use of FP deliverers will increase.

Within long term care, funding is an individual responsibility. The government subsidizes residents only after their assets have been depleted. Government pays the difference between the care costs and the monthly income of the individual.

² Particularly in renovation. The question is what is the government's role in this area in that they subsidize a high proportion of individuals in the home. An advisory committee on capital expenditures has been working on guidelines in this area. Their report was due for release in April 2000.

5.8.3 Role of Advocacy

There appears to be a strong advocacy group in the “Group of Nine”, a coalition of nine seniors groups who regularly meet with the government to discuss issues related to seniors. There are many changes in Continuing Care occurring in Nova Scotia. For example, on March 2, 2000, the government announced the transfer of seniors’ programs and services from the Department of Community Services to the Department of Health. There is not yet a policy directed at the public-private mix in the delivery of continuing care services; however, there was general optimism in the current emphasis being placed in this area.

5.9 **Summary**

The following is a summary of the key issues in the public-private mix from various stakeholders in Nova Scotia.

Government

- Nova Scotia is moving to a single entry system of care to improve efficiencies in the currently separate systems of residential long term care and home care.
- Nova Scotia has the highest per capita debt in Canada. The limited economic growth, continued deficit in the Provincial budget, and the higher than average proportion of 65 and older in the population are all factors associated with the continued policy of individual’s responsibility for the total cost of residential long term care.
- Increased user fees for home care are likely to occur as a result of the governments’ attempts to reduce the debt load (indeed, they were proposed in the provincial budget, April 2000).
- Despite the recent transfer of senior’s programs from the Department of Community Services to Health, there remain two Departments in the delivery of continuing care services as residential care and in home supports to persons who are physically or mentally challenged or mentally disabled remain within the Department of Community Services.

Deliverers of Care

- A fully competitive process for awarding of contracts is not used in either home care or long term care.
- NFP agencies are the primary deliverers of home support and home nursing services in the publicly funded home care program.
- Increasingly, the home support agencies are merging with the Victorian Order of Nurses who deliver the nursing services in order to create efficiencies.
- The acute care sector is discharging people earlier with more complex health care needs.
- While extensive standards exist for agencies that deliver services under the publicly funded home care program, there are no standards or regulations in place for private home care agencies.

- The involvement of FP deliverers are far more evident in long term care residential services. Legislation limits the amount of beds that can be owned by one company/individual to 20%.
- Currently, the FP homes are allowed a profit margin of 10% in the budget they submit to DOH for approval. This profit allowance is in addition to any increased profit they may accrue through efficiencies in the approved budget. In 1998-99, over 5 million dollars of the long term care budget for the province was designated for profit.
- There has been a moratorium on the development of nursing homes in an effort to save costs. This has resulted in a couple of potentially high cost alternatives: 1) In the community, there has been a significant increase in the number of high-end “Assisted Living Units”. These predominately private, for-profit homes are neither licensed nor regulated and encourage their residents to purchase needed services from home care agencies (including home care agencies which are owned by the same company). 2) The QEII Health Sciences Centre has announced an extendicare ward for persons awaiting nursing home placement. The hospital argues that it is less expensive to house these ‘bed blockers’ in a separate unit than on an acute care ward, however, the per diem rates have not been officially released. They are likely far above the nursing home rates.

Clients

- Increased incentive to use all savings to augment public home care with private agencies in order to stay in the community - otherwise all the savings will be used in the residential long term care system (individual responsibility to pay for total cost if income/assets enable).
- The current system allows clients, with sufficient income/assets to pay for the cost of 18 months of care in a long term care facility to bypass an assessment and classification process and access the bed directly. This approach is relatively unique in Canada. It is likely that the recently announced single entry will require all persons entering long term care facilities to be assessed for care needs.
- Understanding what is included in the public system of home care and what needs to be purchased through the private system has been identified by stakeholders as a challenge in Nova Scotia.
- Proposed higher user fees in the near future in home care.
- Clients are increasingly being encouraged to use their insurance for home care services.

Nova Scotia already has a higher than the Canadian average proportion of seniors in its population. There are significant changes underway in the delivery and administration of home care and residential long term care. The driving force behind these changes is to improve efficiencies in the system by becoming more integrated (something most other provinces went through years ago). To date, at least in the continuing care arena, the approach to cost saving appears to be the integration of services and not to embrace the for-profit industry. This may change in the near future when the policies of the recently elected conservative government become clearer. More onus on the individual and/or insurance policies to offset the rising cost of home care may be considered, as well as increased expectations of already overtaxed and under-supported family caregivers.

6. THE PUBLIC-PRIVATE SPLIT: ALBERTA'S CONTINUING CARE SECTOR

6.1 Context

There are 17 regional health authorities (RHAs) that have the responsibility to provide health care services in Alberta. For the year 1997-98, \$554 million dollars of the \$2.4 billion allocated to RHAs was spent on continuing care (including home care). In addition, there are two provincial health authorities (for Cancer and Mental Health), fee-for-service health professionals, and other stakeholders who provide equipment, supplies and services. These authorities provide services to about 2.8 million Albertans, almost 10% of whom are aged 65 and over. This percentage is expected to rise to over 14% by 2016.

The Alberta government establishes the strategic direction for the health system primarily through policy, legislation and standards, the broad allocation of resources, and administration of the provincial programs (e.g., Alberta Health Care Insurance Plan). The RHAs are responsible for hospitals, continuing care facilities, community health services and public health programs.

There has been an active move towards increased privatization in Alberta since the early 1990s. For example, as noted in Feehan (1995), the 1993 report by the Alberta Health Planning Secretariat made the following recommendations:

"Given the need to reduce health funding, it is imperative that new ways be developed to fund services. This should include consumers paying more for those services determined to be non-essential...."

"Sources outside the system can also play a role in supporting new health goals. For example, partnerships can be created between private sector and local associations for wellness promotion, contract health services and so on."

Feehan lists a number of Acts that reflect the Albertan government's desire to increase the level of privatization in the province. There is no mention, however, of the 'private' involvement in continuing or long term care, which has actually been in place for a long time. Moreover, discussions of 'private' do not distinguish between FP and NFP.

This case study was conducted over the period when Alberta proposed legislation (Bill 11, the *Health Care Protection Act*), which will allow private, FP physicians to do a wide range of minor surgeries and have their patients stay overnight (see Evans et al., 2000 and Taft and Steward, 2000). The facilities will be under contract to the RHA and be reimbursed through medicare. Although the legislation, at the time of writing, is a major issue and under considerable debate in Albertan and Canadian politics and health care, there was very little discussion of it with those interviewed in this case study of continuing care in Alberta. The primary reason for this is that continuing care in Alberta, like other provinces, has been delivered through a coexistence of public, FP and NFP organizations for a considerable period of time. As one respondent commented, "*The Klein Bill is irrelevant . . . There has always been a strong mix.*"

6.2 Continuing Care Structure in Alberta

There are three streams of continuing care in Alberta; facility-based (care centres), supportive living and home care (the long term care centres in Alberta have traditionally been known as auxiliary hospitals or institutional nursing homes). Including 'assistive living facilities', as of March 1998, there were 14,396 long term care 'spaces' available in Alberta.

Facility-based care: Eligibility for long term care residential facilities is based on residency; individuals must have lived in Alberta for 12 months prior to admission and been a resident of Canada for at least 10 years, or they must have lived in Alberta for 3 consecutive years during their lifetime. Alberta does not have an income test for accommodation charges. A standard room costs @24.75 a day, a semi-private room \$26.25, and a private room \$28.60. Rates are set by Alberta Health and managed by the Regional Health Authorities.

There are approximately 12,800 individuals occupying beds in Alberta's long term care residential facilities (KPMG, 1999). These long term care beds are provided in Care Centres. These Care Centres are governed by the *Nursing Homes Act*. KPMG notes that their snapshot in time is likely to under-represent the actual through-flow of clients, when admissions, discharges and death are also factored in. Those aged 65 and over comprise approximately 94% of the resident population. Residents are classified according to light, medium and heavy care needs. The number of residents with lighter care needs has been decreasing, such that only a very small proportion of these clients remain in facility care (currently less than 10%). Similarly, the utilization rate has fallen from 105 per 1000 for those age 75 and over in 1988, to 86 per 1000 in 1998 (an 18% decrease) (KPMG, 1999). In contrast, there has been a significant increase in the utilization of Alberta's home care program over the 1990s. Alberta's accommodation rates for long term care (\$24.75-\$28.60) are one of the lowest in the country. (Yukon charges between \$18-\$21, while at the other end of the range, New Brunswick charges clients between \$87-\$118). Nova Scotia, meanwhile, lies between \$85 and \$147.

Supportive living: There are almost 16,000 supportive housing units in Alberta. Just under half of these are lodges (where residents are provided room, board, and may require lower levels of care or supportive services). There is a wide range of services provided in these housing units. These services include meals, social and recreational activities, nursing care, laundry, spiritual support, banking and footcare) (KPMG, 1999). Anticipating a growing demand for supportive housing, one of the recommendations of the Mirosh Report back as early as 1988 (Rec.6.1) was "that private sector, community and non-profit initiatives be encouraged to develop a variety of seniors housing alternatives".

Home Care: Approximately 61,000 individuals received home care in 1996-97 (Health Canada, 1999:p80). Of these, 41% were acute care clients (i.e., less than 3 months), 52% long term care clients and 7% classified as 'other'. About 25.4% received nursing services, 21.9% received home support services and another 12% received therapies (the remaining 40.5% were not classified (Health Canada, 1999:82). Currently there is a limit of \$3,000 a month for home care services.

All Albertan's are eligible for home care based on assessed need from their first day of residency in Alberta (as defined by the *Alberta Health Care Insurance Act*). Clients are charged a flat rate of \$5 an hour for home support services. The maximum monthly charge is based on an income test, which takes into account both net income and family size. Community physiotherapy and occupational therapy are provided through the home care program and the Community Rehabilitation Program. Regional Health Authorities set fees for Adult Day support. These fees cover costs such as meals, supplies and transportation, and vary by program (the range is from \$10 to \$20 a day). Alberta also has the Aids to Daily Living Program in which clients pay 25% of authorized benefits. When the maximum of \$500 per family a year is reached the client qualifies for 100% coverage of benefits.

Continuing care in Alberta has evolved since the late 1940s and 1950s, as nursing homes and the auxiliary hospitals program were developed, based predominantly around the commitment of 'faith-based' or voluntary church organizations. These contributed funding to the construction of facilities. The delivery of services moved away from the public sector to the private not-for-profit sector. The 1964 Nursing Home Program led to the folding in of the private for-profit sector within the publicly funded sphere of long term care. The main reason for this was that private nursing homes were outside the legislation and thus unregulated.

The facility-based sector grew substantially in the mid to late 1960s. Since the 1980s, there has also been a shifting emphasis towards the housing and lifestyle needs of seniors. Following two reports - the Hyde report (1981-82), and the Mirosh Report (1988), the province moved toward the development of a 'system of continuing care'. Home care was first introduced as a program in Alberta in 1978. At that point, only individuals with medical needs received assistance. In 1984 more services were introduced for palliative care and support services, and then, in 1991, the program was expanded to include support services for those under 65, whether or not they were receiving professional services.

6.3 Financing and Delivery

The basic structure of financing and delivery of continuing care in Alberta is shown in figures 1 and 2. Figure 1 shows that the flow of public funds begins with the allocation by the provincial government to the respective RHAs. From there, the RHAs contract out for services in residential settings (i.e., care centres and supportive housing organizations/assistive living accommodations), and organizations providing home care. Within the facility and supportive housing streams there is a mix of public and private ownership, and within 'private' there are FP organizations and NFP organizations). In the home care stream professional services, including assessment and discharge planning, are provided predominantly, but not exclusively, by the RHA, while support services are provided by a mix of FP and NFP agencies.

Thus with financing, the system is focused on the government and the RHAs. Then, at the interface of financing and delivery, a contracting process allocates funds for services that are delivered by a mix of public, NFP and FP organizations. Running in parallel to the publicly funded system is the direct financial exchange for services between private run organizations (FPs and

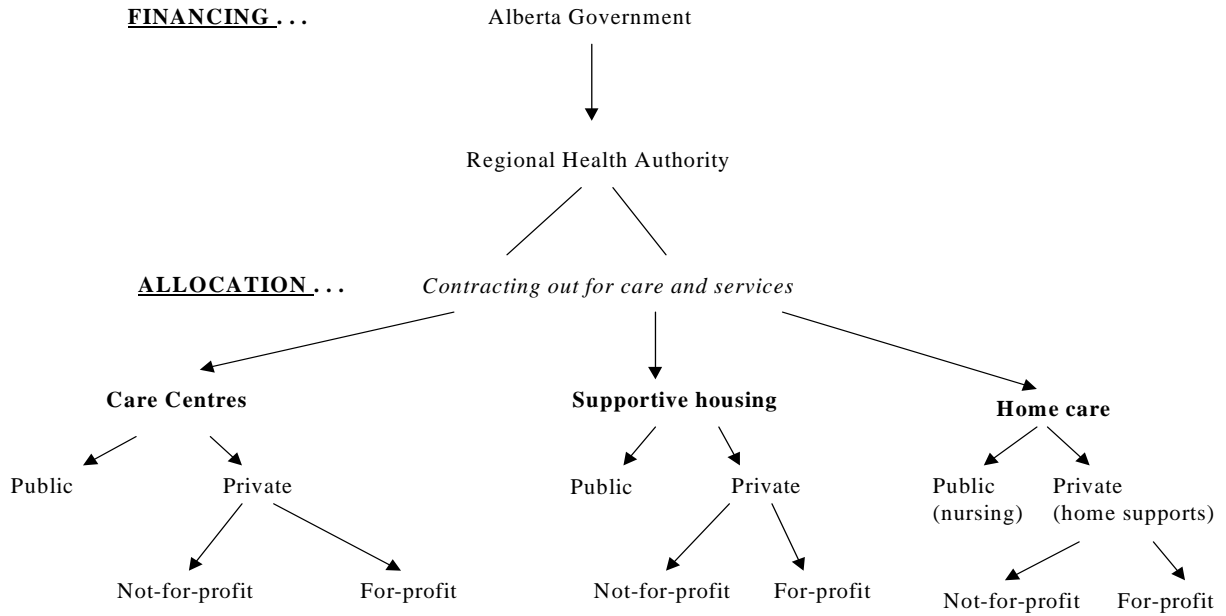


Figure 1: Flow of public funding for continuing care in Alberta

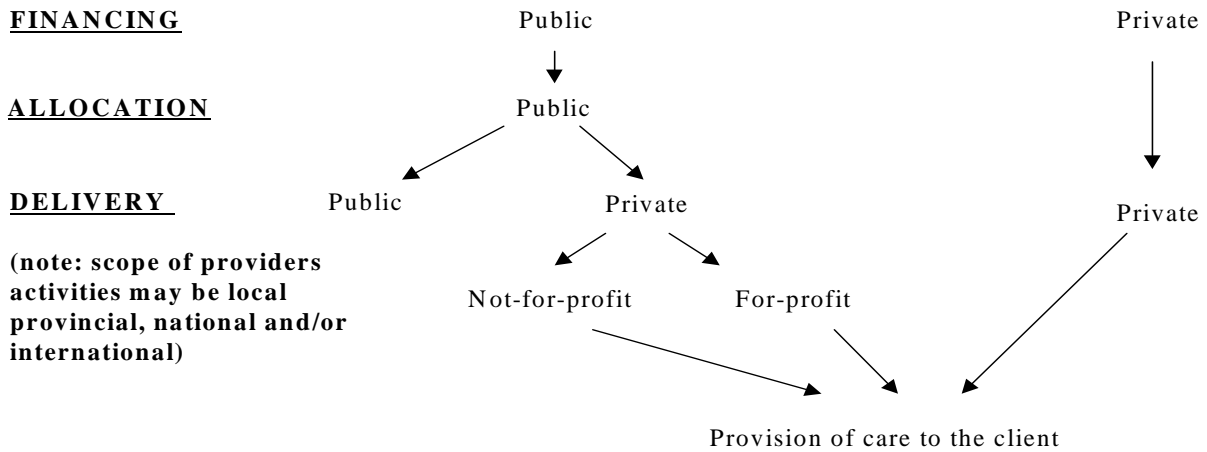


Figure 2: The financing and delivery of Continuing Care in Alberta

NFPs) and the general public. Implicit in this organizational structure are varying forms of ownership. Indeed, it is perhaps more the issue of ownership, rather than the private-public split per se, that is central to the concerns of various stakeholders.

Figure 2 illustrates the financing and delivery of continuing care in Alberta. Ownership can be local, provincial, national and international. It is commonly accepted that the *type* of ownership in the continuing care sector may change, and this will have a significant bearing on the nature of 'the industry' in the future.

The fiscal imperative that has framed much of the reform in health care characterizes the Albertan continuing care sector. Caps on budgets in the early 1990s and the use of competition through the Regional Health Authorities (RHAs), as the basis for determining which organizations provide care, have created opportunities for private market growth.

It can be debated as to whether these transformations have squeezed out waste in the system or have negatively affected client care. To many observers, there are a number of specific issues requiring resolution. Indeed, this is supported by the recent review of Long Term Care in Alberta (Alberta Health and Wellness, 1999), which identified the following:

- people have few choices;
- supportive housing is just starting to develop;
- there are few programs to help people stay "healthy and well";
- the focus has been on people going to services, not the other way around;
- services for seniors are not well-coordinated;
- many of the current LTC centres are old and out of date;
- there is little training in geriatric medicine; and,
- there is increasing stress on informal caregivers.

There are many more issues, as will be discussed in this study, that characterize the state of continuing care in Alberta, especially with regard to the mix of public-private involvement.

The above findings come from the November 1999 provincial government report '*Long Term Care Review*.' The Broda report, as it has become known, is the culmination of a comprehensive two year review of continuing care and involved extensive consultations with Albertans. The Broda report makes 50 recommendations for long term care in Alberta. The first recommendation is to address *immediate needs* by:

- increasing support for home care services;
- expanding home care in supportive housing arrangements;
- increasing funding that is targeted at increasing the number of front-line staff ("to address the increasing level of people in long term care centres");
- increasing funding for RHAs that will enable them to provide space/beds for people with complex and chronic health problems; and,

- "for people with less serious problems, the priority should be on expanding home and community care, providing respite care for informal caregivers, and expanding supportive living arrangements".

Over the longer term, a number of the recommendations have some bearing on the discussion that follows. These include:

- accommodation charges be increased in continuing care centres (but along with subsidization for those who can not afford the higher fees);
- these fees be used to improve services and establish a 'capital pool' for upgrading facilities;
- an increase in home care charges for daily living services (again, along with subsidization for those who can not afford the higher fees);
- support for capital for continuing care facilities should be a shared responsibility among the individual (through 'rental' payments), the operator and the provincial government; and,
- more support for informal caregivers

Recommendation 31 also calls for the creation of a *Continuing Care Act*. This would attempt to combine all the relevant aspects of legislation and regulations related to continuing care under one act. There is no discussion in the Broda report recommendations of the public-private mix in continuing care, and no mention of any distinctions between private and public involvement in the delivery of services.

The remainder of this portion of the study is based on the interviews conducted and focuses on the nature of the private-public mix in continuing care and the issues that emanate from that structure.

6.4 The Public-Private Mix

"There is too much emotion around the private/public issue, it doesn't help the debate."

"People want choice, and the private market is willing to take a risk"

"Alberta has a great hybrid of private and public services in continuing care—it's been operating like this for twenty years."

It is clear that as the population ages, there needs to be a system that can be responsive to the needs of this population. Changing the system because of the demographic imperative has an implicit cost dimension. Indeed, the issue of cost figured prominently in our discussions with stakeholders.

The key issues that emerged in the interviews emanated from the drivers of change; the roles of capital and labour; the aging population; and changing values. The transition that is seen to be occurring is based, to a large extent, on the role capital has played, and will be playing, in providing the long term care facility infrastructure, and the associated need and demand for labour. In the community context meanwhile, like elsewhere in the country, there is an ongoing shift in emphasis

towards the provision of post-acute care, at the expense of home support services. A number of sub-issues also emerged, some of which reflected differences between private and public roles, and between for-profit (FP) and not-for-profit (NFP) organizations.

6.4.1 Issues in the Delivery of Continuing Care

All three sectors (i.e., public, FP, NFP) in the facility-based care stream operate under the same rate, the same case mix index, the same monitoring functions and the same funding formula, which is set across the system. If acuity goes up, the organization receives more funding. Where the differences come in is in how they use the funds and the level of efficiency.

NFPs and FPs compete with one another *and* publicly funded organizations in continuing care. There is clearly a distinction drawn between NFPs and FPs, more so than between private and public. A common perception is that FPs are in the business of making money, whereas the NFPs, and in Alberta most of these have voluntary church organization backgrounds (and are also referred to as ‘faith-based organizations’), and are considered to have a much stronger caring and community component. The relationships between the NFPs and FPs appear positive, building on the fact that they have coexisted under various models for a number of years.

At the interface between financing and delivery is the allocative process. With RHAs it is the tendering process. There are two drivers in the marketplace: provider readiness (dependency, entrepreneurship), and purchasing capability. Provider readiness refers to the ability of the organization to respond to the tendering process. This will have a strong bearing on the market share that they obtain. ‘Dependency’ refers to the fact that there is a perception that some NFPs are considered to be still in a dependency mode for government funding (now through RHAs) and not fully aware of the need, nor have the skills, to compete in a tendering process.

“One expects a business-like approach but we see here a dependent bunch of providers dependent on government. They are ‘private’ in name only and they’re not thinking about ‘need’ and how to improve themselves.”

“If you want to go from more dependent to entrepreneurial [you] must have a business approach. Must have an element of risk, to make public-private really work.”

“There should be no difference between a good operator of a FP and a NFP. The public sector does not have to be sloppy and ineffective - these are bogus arguments.”

‘Entrepreneurship’ refers to the organization’s ability to become a leader in the market through innovative approaches and fully embracing a business approach to the delivery of care. One public organization, for example, commented that it pursues innovation because of a strong desire to provide good services, and a philosophy to be a leader. The prevailing view, however, is that FP organizations have a greater understanding of the tendering process. *“There may be more for-profits to emerge. They are much more aggressive in responding to RFPs in continuing care. They come in and have the business end of it.”*

Purchasing capability refers to the RHAs ability to design the tendering process such that it brings out the RHAs desired shift in how care is delivered. Contracting by the RHAs is central to the delivery of continuing care. *“How you develop your tendering documents can be a real struggle. We said here’s the volume, show us the price and how you’d do it. And do you include the bands of price rates of pay for staff? Do you then become too micro-managerial with labour issues?”* Moreover, there is a fine balance to play in determining the right bid to accept. *“You walk a fine line between a good price and too good a price”* (i.e., too good, and perhaps an organization can not fulfill promises). *“How you influence markets is the way you determine purchasing arrangements. To be a good purchaser you need good data and good tools. Contracting out is not a freebee. Purchasing is expensive work.”*

Although the organizations are on level playing fields in many respects, in other ways there are differences. NFPs have the ability to do fundraising whereas FPs are given little opportunity for this to occur, unless they set up some form of foundation that enables specific fund raising to take place. Fundraising can enable the provision of specific services, so for example, Bethany, a NFP organization, has 5 staff for spiritual purposes, and a palliative care nurse. As one CEO of a NFP commented, *“If it was not for fund raising, the ability to differentiate on the service side [between FPs and NFPs] would be much slimmer.”*

NFPs can also play a strong advocacy role (e.g., for seniors issues), and can do so quite often through their fund raising capacity. The public sector organizations do not have the same ability to advocate because of the perception of the right arm attacking the left arm. FPs have difficulty advocating because of the perception that there is a profit motive.

Public facilities must also open their books to the public, and there is a perception that they often take on complex care needs that other facilities would not touch. Whereas NFPs do not have to make ‘x%’ return on investment for shareholders, if they do have revenue exceeding expenditures, this is typically fed back into the operations of the organization. A perception of NFPs is that they feel they are truly caring and contributing to making a better community. *“Our job ... accompany the loss with people as they age.”* A common perception of the FPs is that profit is their incentive, even though they must pay full GST, business tax, and property tax. In contrast, the NFPs can access grants and public funds. From the publicly funded perspective, one view is that *“for-profits look at money, whereas with public, we look at breaking even. . . We will not panic if we don’t do that, especially if an individual’s life is better off - we’ll pay for dentures if the client can’t. If we “make money” we’d have it taken away by the Health Authority, so there is no benefit for good management . . . can’t take it into next year.”*

6.4.2 Facility-Based Care

The overall themes to emerge from the interviews are that the provincial government has a strong desire to "*get out of the business of building buildings*"; that the nature of the continuing care system is such that increasing involvement of FP organizations is anticipated, especially given the high demand for long term care beds; that the private system is growing (i.e., care or services funded and provided to individuals outside the publicly funded system); and that the publicly funded system will potentially become more dependent on FP organizations in both the public and private spheres.

A number of stakeholders emphasized that the government no longer wishes to be putting capital into the construction of long term care facilities. "*Government wants to be moving away from owning buildings*". The incentives for government to be less involved in infrastructural development are: 1) that society can not afford the costs of institutionalization at the current rate, and 2) that the values currently held are that individuals should remain in the community for as long as possible.

Perhaps the strongest views expressed were those regarding the cost imperative and the implications for building facilities in the system. The key question is: How is capital going to be financed? - through raising taxes, or through the user-pay's principle, with higher accommodation charges for individuals. As the government moves away from 'building buildings', the common belief is that it will become more dependent on the private sector (FP and NFP) to build the facilities. Even the publicly funded Carewest organization in Calgary is partnering with a private developer to build a new facility.

"They [private] may be willing to do front-end - e.g., mortgage, but they will expect money from clients and the . . . Health Authority to subsidize these."

"If they [the government] want to get out of the business of building buildings then for-profits seem logical."

We heard from stakeholders that, generally, it is the FPs who have the resources to build, and of these, it is the larger national and multinational companies that have the resources for such outlays. If a FP chose to build a 125 bed facility, it would cost approximately \$13 million. Capital costs can be recouped over 20-25 years, and profit would be embedded in the costs (much of which would come from individuals). FPs can potentially gain greater control of the market and be recouping costs over time. Meanwhile the provincial government may develop a growing dependency on the FPs. More of the public funds and individual's money for continuing care would go into paying off the capital investment, and would subsequently mean increased profit margins for these organizations.

Over time, the public sector can become heavily dependent on the private FP sector. One of the benefits to the government, however, is that capital investments will not appear as expenditures in the current year; rather, public expenditures will be folded into long term, contractual relationships with providers and so the true cost will be absorbed and 'unseen' to the public over time.

What may be more of a concern is the ownership of these FPs. *“Even within the FPs, there are the Ma and Pa operations and the larger corporations - the Ma and Pa’s can’t absorb or share the risk, whereas national and international companies can leverage markets . . . risk sharing with a greater pool.”* Although the Broda report de-emphasizes the role of institutions, there is still an excess demand for beds. There is little competition because of the shortage. *“So long as there is a shortage there is no competition”*. This, however, means it is an ideal ‘market’ for an organization to get into and expand. Hence the interest from other organizations outside of Alberta and Canada in establishing some presence in Calgary, and the possibility of some FP facilities opening beds or building more for individuals who will pay outside the publicly funded system.

Although local FPs may comment, *“We don’t want to compete with the big multinationals,”* they may have little choice. For the RHAs and the Albertan government, there is the potential for more and more care to be provided by outside FP interests, especially if they can prove that they are more competitive in the bidding process than the Albertan based NFPs and the Albertan based FPs. Indeed, greater US involvement can be anticipated as North American and international trade agreements open up market opportunities in Canadian health care. There are also plans for some FPs at present, currently receiving clients from the public system to build additional facilities designed to cater to the private market.

There has been a recent rise in supportive housing, both within the publicly funded system and also in the private stream. The incentive for private industry to get involved in building congregate style housing is that there is a demand for such complexes and a limited supply. With the slow down in care centre development and a lack of funding for the lodge program, there are opportunities for entrepreneurs to capture a market, particularly the more upscale market, for assistive living. These can offer dedicated staff, a range of services and continuity of care 24 hours a day. At present, there is excess capacity in these upscale private residences. Given the demand in the public system and the lack of public capital available for further construction of residences, some RHAs have approached these private residences to see if they can take on the greater public demand. One could question if this may lead to a greater dependency on the private sector for supportive housing.

There is also a significant rise in ‘private personal care homes’, where you pay \$600-\$900 a month (3-4 people and run by a family or small business). These are unregulated, although the Calgary Regional Health Authority has started to develop minimum standards.

“If you can buy the care you want—why not?”

“There is no significant odour to being a private sector owner—it keeps the costs in the system down.” (FP owner)

Another significant issue to both public and private interests is the shortage of human resources and the low wages for the sector. This is reflective of the country as a whole, but it is central to the development of an effective system. In other jurisdictions, it is widely felt that the increased presence of FPs that are non-unionized is having an overall depressive effect on wages and making community-based care less attractive, when compared to the institutional settings. Irrespective of the

unions, however, there is an ongoing struggle to retain staff as the institutional settings provide better wages and more stable working conditions than do the community-based jobs. A general concern regarding the Broda report is that more attention should have been given to the human resource issue, and in particular, to increasing salaries. Overall, there is a shortage of nurses in the public system.

“You have nurses making \$10-12 an hour and you have caretakers making \$16-18 an hour!”

“We need more money to upgrade salaries - nurses and nurses aides ... we’re almost competing with McDonalds!”

6.4.3 Facility Care Clients

The prevailing view, and indeed more explicitly stated in the Broda report, is that individuals will have to pay more for their housing. This higher level of payment will be directed to payment for services, but more significantly for the capital expenditures. The facilities will use a greater proportion of the fee to cover capital costs if required. The capital outlay will be repaid over time as fees accrue to the facility.

The current accommodation fee is well below the pension, and well below most other jurisdictions in Canada. Individuals can also pay for a range of ‘hospitality’ items. The Broda report maintains that professional services should still be paid by government, but supports to daily services - personal care and homemaking, should be paid by individuals. Currently, the cost is so low that there is almost a reverse incentive in place - as given the low cost, clients can enter a nursing home as a financially more viable alternative to remaining in the home. The idea, however, is to eliminate the incentives to discourage moving into the institutional setting.

There is also the expectation that individuals will be means tested to ensure that those who can not afford to pay for services can be subsidized to ensure they can still receive these services. *“We would rather say ‘who should you subsidize versus who should you charge’.”* But, as clients get sicker, greater supports will be required as they remain in the community. At what point then does it cost more to keep these clients out of the institutions? And if the community-based costs exceed that of the institutions, does the public system absorb these costs? In other words, do the values associated with having individuals remain in the community have a greater influence on the site of residence than does the issue of costs to the public system?

Somewhere in the continuing care system is the client. If a FP organization can achieve the same client outcomes as a NFP, does it matter whether they receive a profit or not? Does it then send a message to the NFP that they can improve their own delivery of services - hence the benefits of competition. A major issue here perhaps is defining what the expected client outcomes should be. These may include ‘increased quality of life’, ‘improved quality of care’, ‘increased quality of services’ and so on. One NFP CEO observed, *“You can’t segregate the quality of care based on ownership.”* If all things are equal, then is there any basis upon which to be concerned about FP involvement in providing care? One can also again raise the issue that if the expected outcomes can be achieved through FPs, and those FPs are non-Canadian, should there be concerns that this is how

continuing care is provided? Will there be much choice in this decision anyway if it is shown that multinational interests can build facilities at a cheaper cost than local interests, and, therefore, potentially have a lower per diem to charge the client (the reality perhaps is the rate would remain the same, but the multinational stands to make more money on its investment when compared to local interests). Many value judgements will be required.

One of the biggest issues today is family expectations. As one CEO observed, "*What they think they should be getting is much more than the resources we are given . . . families have changed - expect more - whereas in the past families came from the depression where there was not much available.*" Another commented, "*Families . . . that's where it all breaks down.*"

"*Government is still thinking of the family of the fifties*", which had two parents, an extended family, larger and more closely located to one another. But now 'the family' has changed considerably - more women are in the workforce, grandparents are living longer, there are more single parent families, and families are geographically dispersed.

6.4.4 Home Care

Home care in Alberta is regulated under the Co-ordinated Home Care Program Regulation of the Public Health Act. This describes the types of services available and the extent to which individuals may have to pay for some types of services, depending on their own financial situation (for further details go to www.gov.ab.ca/qp/ascii/regs/85_239.TXT). There is a mix of public and private (FP and NFP) organizations in home care in Alberta, just as there has been for a number of years.

There is a higher acuity level of clients receiving home care due to the waiting lists for facility-based care, the closing of hospital beds, and the increasing levels of acute care substitution. This is putting pressure on the system, for although funding for home care has increased substantially over the past 10 years (e.g., in Edmonton from \$8 million in 1991 to \$50 million in 1999), it has not kept pace with the demand. Despite the increased funding, services have actually been reduced, "*We do not offer homemaking - nobody likes it but that's the reality.*" Indeed, as one RHA official commented, "*Whenever it [waiting list for LTC facility] goes up, it creates a funding crisis in home care . . . The deficit is a bit of a roller coaster, we've let it grow by crisis, then you know it's real.*"

The story is the same as in other jurisdictions. Hospitals are releasing individuals sicker than in the past, which is placing increased stress on the families. "*There are people in their homes who normally would still be in the hospital*". "*We can't give more services . . . the bottom line is home care has a limited amount of resources to give out*".

There is a mix of FP and NFP delivery agencies in Edmonton and Calgary that bid on contracts tendered by the respective RHAs for home support services. Professional services are provided by the RHAs. Edmonton operates on a quadrant system whereby the city and outlying areas are divided and certain agencies have responsibility for providing services in each of the quadrants. There are discussions underway for Calgary to adopt a similar system.

Contracts are tendered on a regular basis in Edmonton, whereas those in Calgary are only offered when it is considered that an additional provider may be required. In these cases, they do not ask the existing providers to resubmit their contract bids. The relationships made with the private agencies are based on 'non-committed' or 'open' contracts, in that the RHA is not bound to pay for 'x' amount of hours service from an agency. In Edmonton, there are also 'Designated Buildings', whereby a Lodge or a Seniors Apartment is specifically assigned to an agency. The block funding for this type of contract is based on historical utilization; if the costs exceed the historical costs, then the agency will receive additional funding. Conversely, if there is less service then the agency will be expected to return the unspent portion of the dedicated funding.

In Edmonton, the competitive bidding on contracts tendered by the Capital Health Authority is based on quality and not price, as there is a flat billing rate established with all agencies. Quality is, in theory, determined by elements such as client satisfaction, the demonstrated ability of the agency to provide services in a timely and reliable manner, and the number of complaints that the RHA may have received concerning the agency. In contrast, the Calgary Regional Health Authority tenders contracts based on price and quality, such that agencies will propose different billing rates in their bidding to the RHA.

In reality, the agencies work hard at building their reputations and developing relationships with the RHAs. It was stressed by several interviewees that a key factor in the allocation of service time to agencies was a function of the relationships established with RHA case managers. Service quality must still be present, but it is the case manager who determines which agency will be contracted to provide services to an individual.

There were no noticeable distinctions made by FPs or NFPs about the differences between the different types of agencies. As one interviewee commented "*It's something that never comes up - that you're a non-profit or a for-profit . . . Clients just look at the best quality.*" Another added, "*We all sit around the table, it's a pretty supportive environment.*" Nevertheless, the issue of foreign or Canadian-ownership has come up, as some agencies will promote themselves as Canadian-owned. But as a foreign-owned agency simply commented, "*We have a very good reputation based on the services we deliver.*"

More significantly, however, from the perspective of one senior health official, there are benefits to having a competitive model with a mix of FPs and NFPs. FPs are seen as more cost efficient and the NFPs as "value added", in that they provide specialized and new services. The two types of agencies learn from one another as they meet and discuss the delivery of home care as a group on a regular basis. Meanwhile, FPs have been seen in a positive light. As a senior health official observed; "*They are committed to the industry - they don't want to be less compassionate, caring or responsible than NFPs.*"

FPs endeavor to stay lean and focus their resources on direct service provision. If they need to provide training or education for workers they will do this on an as-required basis, instead of committing resources for this in-house. Such 'flexible specialization' is reflective of the business world and other industries as they have evolved over the past fifteen years. Even NFP agencies are

engaging in forms of more traditional ‘for-profit’ activity, as they will provide services directly to clients on an individual basis outside of the publicly-funded envelope.

One of the key ‘current’ issues identified by both NFPs and FPs is the issue of travel reimbursement for home support workers (i.e., travel time). RHAs are not billed specifically for travel, although in many instances agencies will reimburse their workers for travel mileage. There is a question of whether not paying for travel breaches labor regulations in the province. Alberta Labor is in discussions at present with Alberta Health to determine what course of action should be taken. If Alberta Health is required to provide funding for travel mileage then this will have a substantial effect on the RHAs and the costs of providing home support services to clients.

There is very little difference in the rate of pay for home support workers amongst the agencies, and what differences do exist are not conveniently divided between FPs and NFPs. The low level of wages for home support workers was identified by both FP and NFPs as a significant issue. Hourly wages can range from \$7.60 to \$9.00 with the average wage being \$8.50 an hour. All the agencies have varying pay and benefit structures. *“If home care is to work there must be money injected, especially [for] home support workers, who are the lowest, [they] should expect more money.”*

Many home support workers will work on a casual basis with more than one employer in order to get enough hours to make a living. Agencies would like to be in a position to pay more in order to keep staff. Indeed, one NFP agency commented that they would like to pay more in order to keep their good staff, but that would essentially mean having to run a deficit.

There were concerns expressed by both FP and NFP agencies that there needs to be more financial support for providing training for home support workers. With the smaller agencies, it is difficult to absorb costs for training and workers often are expected to have completed courses themselves. There was a concern expressed, however, that there is no core training program available; *“We don’t have a standardized program to do training ... there’s a hundred different courses available.”*

6.4.5 Home Care Clients

Although clients are able to choose which agencies they would prefer to receive services from, agencies themselves commented that the clients are, in fact, often not advised of this option. The prevailing view by both agencies and RHAs was that clients see a ‘system of home care’ and it matters less as to which particular agency is providing the service.

In response to the changing home care environment, insurance companies are taking on a much greater role. The increased role of private insurance reflects a perceived need for these services and an opportunity for clients to access services they feel will not be available in the publicly funded system. It is not uncommon for insurance policies to offer individuals up to \$10,000 for nursing care, and more and more insurance companies are offering coverage for home support services. In some

instances, case managers will ask clients if they have private insurance or not, as that may have a bearing on the services provided through the RHA.

The increased insurance company involvement complicates the financing and delivery of home care. A client, for example, may be assessed as requiring a certain level of care that can be provided by a home support agency. The client's insurance, however, may only cover nursing services and not home support services, and so the client would not be eligible for additional services other than the professional services assessed by the case manager. Navigating through the insurance system is problematic for many seniors, but those younger are looking much more closely at insurance as a means to provide what they consider essential care in the home. Again, this reflects the growing perception that the publicly funded system may not be able to provide the care in the future.

When home supports were reduced recently in Edmonton, clients who lost services adopted a number of different strategies. These included: paying privately for services, paying their home support worker 'under the table' (which for the workers actually resulted in more 'take-home' pay), increasing their level of family support, or simply doing without the services. As one agency operator commented: *"If their hours get cut back it's a pretty desperate situation for everyone ... clients, and us losing workers."* Similarly, in Calgary, *"We did see an increase in private, but not dramatic use."* Also, from an agency in Edmonton, *"By giving clients 'x' amount you're band-aiding them ... they really require more care. The amount of care is very limited."*

An often cited example was that of a bath for clients. A few years ago, clients would have been given one and a half hour's for a bath, but this has been reduced in some instances to just 30 minutes, once a week, which is very little time to provide the personal care that is required. One agency director commented, however, that in some cases, after years of *entitlement*, there were some clients who did not actually need services. And now with a shift to eligibility rather than entitlement it has become apparent, when assessed, that many individuals no longer need services.

In many cases, clients are unaware whether the workers providing home care are from a FP or a NFP agency. And with the professional services being publicly delivered by employees of the RHAs, the distinctions get even further blurred. So long as it is publicly funded, the actual delivery of care does not appear as an issue at all for individuals receiving care. The important thing from a client's perspective is that care is being provided. What is more the issue, is the level of care, and the erosion of the home support services.

Finally, one agency director noted that we tend to focus on billable hours of care, when in actual fact there are many volunteer hours put in as well. Many home support workers will work longer than what they are paid for in order to give the clients what they need. *"This is a hidden kind of service you don't see in the books."*

6.5 Summary

From the limited number of interviews conducted, a number of points can be cast in terms of incentives and disincentives in continuing care in Alberta. We have listed these below from the perspective of various stakeholder groups. The list is by no means exhaustive, especially in light of the small scale of this case study, but it does reflect some of the complexities and shifts occurring.

Government

- Government is shifting the costs of care onto privately run organizations to reduce capital outlay and, therefore, annual expenditures. This, in part, reflects its recognition of the growing demands that will be placed on the continuing care system. It also reflects the current political climate in Alberta and the historical context.
- Government has stated that it is shifting the focus of continuing care away from institutions because of current and anticipated higher costs, and the desire to improve the quality of life for individuals.

Regional Health Authorities

- RHAs are contracting with NFPs and FPs to reduce costs and enhance the quality of care through the competitive model.
- RHAs and private agencies are making individuals aware of private insurance options because of the current demands for services and the limited resources available in the publicly funded system.
- RHAs are decreasing home support services because of increased costs.
- RHAs have huge waiting lists for services and institutional beds because of the increasing demands for these types of care. To some observers, they are using these lists as a political tool to force the issue with the government.
- RHAs are contracting directly with private organizations 'outside' the publicly funded system for these organizations to take on 'public' clients because of the high demand for institutional care.
- The acute care sector is discharging people earlier and sicker, thus putting additional pressures on home care.

Public and private delivery of care

- Public organizations have gone over budget because clients have a recognized need for care and there is no incentive to keep within budget. At the same time other public organizations are being innovative with service delivery because of the competitive marketplace place.
- There has been an increase in for-profit home support agencies in Calgary. This is in contrast to Edmonton where there has been a mix of for-profit and not-for-profit agencies for over 20 years.
- FP institutional care is expanding the number of beds because of a recognized growing demand.

- FP assistive living arrangements are increasing because of a recognized growing demand.

Human Resources

- Home support workers have increased their 'volunteer hours' in the wake of reduced services because of the recognised need for many clients.
- There is little incentive for home support staff to obtain education and training because of the low wages, uncertain hours and the work environment. For these same reasons, and for the high demand for home support services, there is a high turnover of these workers, and also shortages.
- Home support workers are often employed on a casual basis in more than one agency because of the low wages and uncertain hours.

Individuals

- More individuals accessing private sources to get 'needed' services' not available in the public system.
- More individuals obtaining private insurance to ensure access to services when and if required later.
- High demand for institutional care as it is needed, and currently there is no financial incentive to remain in the community versus in a facility.
- Individuals are hiring home support workers under the table because the publicly funded services have been cut.
- Increased reliance on families as the services have been cut.
- Individuals are going without services because the services have been cut.

Alberta's continuing care sector is at a cross-roads. The Broda report lays the foundation for significant changes in the sector and it is now over to the Albertan government to determine the extent to which they adopt the many recommendations outlined. It appears, however, that there will be less government involvement in capital investments, and that individuals not below the threshold for welfare assistance can expect to be paying more for continuing care. One can speculate as to the potential for growing for-profit involvement, but given that there has already been a long period of for-profit, not-for-profit and public existence in the sector, such shifts may meet with very little concern by the Albertan public. Of more significance perhaps, will be the extent to which the government can effectively control and determine the quality of care provided, and provide the funding necessary to respond to the fundamental changes occurring with the demographic profile of the population.

"Health care should be building humanity not developing market forces."

"In Alberta there is a love affair with FP's. Its as informed as any love affair."

"Then you ask yourself, what kind of industry do you want? Who decides? We aren't very good at asking this question very much and we certainly aren't very good to answer it."

7. CASE STUDY SUMMARY

In Section 3.0 we provided a table outlining seven key dimensions which provide the context in which the split between public and private roles in health care is evolving: demographic imperatives, fiscal imperatives, political context, ideology, human resources, evolution and vision, and access. In both Nova Scotia and Alberta the environment is currently conducive for increased levels of privatization (and profitization). The extent to which this occurs, however, will be predicated on the population's engagement in the political process to determine how care should best be provided. Indeed, at the time of writing the Albertan government is being taken to task by the public with regards to perceived profitization through Bill 11.

The classification of public and private outlined by Deber et al., is useful for examining the differences between Alberta and Nova Scotia. At a broader level, the jurisdiction for continuing care is a provincial responsibility - the Canada Health Act legislated by the federal level does not apply to continuing care services. Within these two provinces, Alberta has devolved the responsibility for continuing care to the regional level, while Nova Scotia continues to centralize decision making in continuing care services. Consequently, following the geographical logic outlined by Deber et al., the public involvement in Alberta must be recognized at provincial and regional levels. This additional layer raises the complexity of discussing one policy of private-public involvement in continuing care services. While Nova Scotia does not have the additional complexity of regionalized financing and delivery, it has the added complexity of a different approach to public-private *within* continuing care, that is, residential long term care compared to home care. Consequently, the policies for public and private do not vary by region (although there is limited access to alternative private care in rural areas), but rather by program.

The conceptual differentiation of financing and delivery is particularly useful in comparing Nova Scotia and Alberta's approach to public and private involvement. A simplified generalization would be that the Alberta system tends to support public financing of private delivery, while Nova Scotia encourages private financing of private delivery. These generalizations are discussed in more detail below.

Financing refers to the extent that services are publically or privately funded. In Nova Scotia, within residential long term care, the emphasis is on individual or private financing of the publically regulated system. This is significantly different from Alberta where the public system provides substantial subsidies to the cost of beds in long term care facilities regardless of the individuals ability to pay. The approach to home care services is similar between the provinces in that the assessed nursing care needs are financed by the public system and user fees for home support services enable shared responsibility for financing.

Delivery refers to whether the organizations that deliver services are public or private. While both Alberta and Nova Scotia emphasize private delivery, distinctions between the two provinces arise within the definition of private. Specifically, differences in the involvement of for-profit versus not-for profit organizations are evident. [There is no evidence of differences in the involvement of voluntary organizations or family caregivers in the delivery of care]. In Alberta, greater inclusion of

for-profit agencies in the delivery of home care services is evident in particular regions while in Nova Scotia not-for-profit agencies deliver most of the care required.

This case analysis has highlighted the differences that exist between two economical and ideological diverse provinces in Canada. These provinces are distinct in their organization, financing and delivery of continuing care services, on the amount of research and policy formulation that has occurred over the past decade, the state of their economies, and in terms of their changing demographic profile. What this analysis has also revealed is that some of the key issues affecting long term care, the capital expenditures of nursing homes, the delivery of care in rural settings, achieving the best balance of public and private mix in the system . . . continue to challenge government in both jurisdictions.

Irrespective of the jurisdiction under examination, policymakers are still faced with the overriding logic that if for-profit organizations are in the business of delivering care and it is, from the government's perspective, for the purpose of system efficiencies, those savings from the efficiencies are reflected in 'profit margins' for shareholders or owners, which may not be fed back into the system.

The questions then become value-based. Should people derive profit from the delivery of health services? If so, then how much is 'acceptable'? Should government be concerned that foreign multinational corporations are making profits out of the Canadian health care system? Should government fund for-profit organizations in health care, especially if people will pay privately anyway for these services? And if people are willing to pay privately, should we be concerned that government is paying such organizations to deliver services to those who *may not* be able to pay privately?

Because continuing care in Canada is for the most part outside the *Canada Health Act*, there is a mix of public and private, for-profit and not-for-profit in the system that have co-existed for number of years. Anecdotally, however, it appears there is a growing amount of continuing care now being provided outside the public system. Based on the interviews in this case study, it appears that individuals are increasingly paying for more services privately, outside the public system. This reflects both the erosion of services inside the system and the market response to the demographic, fiscal and political imperatives currently characterizing the country. How large that shift to the private payment and delivery of care is unknown, but an understanding of the nature and extent of this change is critical if we are to fully understand the requirement for publicly funded continuing care in Canada.

APPENDIX A: INTERVIEW QUESTIONS

Name _____ Date _____

1. What is your perspective on the changing nature of the involvement of for-profit versus not for profit organizations in the delivery of home care?
2. What does it mean for clients? For providers? For funders / government?
3. What is your perspective on the changing nature of the involvement of for-profit versus not for profit organizations in the delivery of long term residential care?
4. What does it mean for clients? For providers? For funders / government?
5. What are the incentives and disincentives of operating in a private pay system for home care?
6. What are the incentives and disincentives of operating in a private pay system for long term home residential care?
7. What is the impact of user fees on how home care clients use services?
8. Are private pay individuals given preference over government subsidized individuals in the residential long term care sector? What are the differences (e.g. advantages of) between private pay and public / state funded clients? For example, what impact does the ability to pay have on access to long term residential care?
9. How is means / income testing used to determine who is eligible for public funding in long term care?
10. How is means / income testing being used to determine the client's level of contribution for home care?

APPENDIX B: INTERVIEW PARTICIPANTS IN NOVA SCOTIA

Dean Hirtle
Director, Long term Care
Department of Health

Sandra Cook
A/Director, Home Care Nova Scotia
Department of Health

Sue-Ellen Murray
Senior Policy Analyst, Long Term Care

David Macdonald
Senior Policy Analyst, Home Care
Department of Health

Wade Were
Senior Policy Analyst, Long Term Care
Department of Health

Judith Wood-Bayne
Health Canada

Karen Slaunwhite
Executive Director, Home Support Nova Scotia

Carol Davis
Administrator, The Berkley

Helen Patriquin
Nova Scotia Association of Health Organizations

Lloyd Brown
CEO Northwoodcare Inc.

Patricia Jennex
ComCare Health Services

Carolyn Moore
Registered Nurses Association of NS

Susan Gray-Marmoroff, Supervisor Assessment Services
Home Care Nova Scotia

Anne Yuill, Associate Regional Director
Victorian Order of Nurses,
NS Division

Judy LaPierre
Community Support Specialist
Department of Community Services

Billie McCready, Executive Committee Member
NS Association of For-Profit Home Health Care

Mary Wile, Director
We Care Home Health Services

Ann Fontaine, Director of Clinical Management
Olsten Health Services

APPENDIX C: ALBERTA ORGANIZATIONS THAT PARTICIPATED IN INTERVIEWS

Alberta Long Term Care Association
Bethany Care Society
Beverly Centre
Bow View Manor
Calgary Regional Health Authority
Capital Region Health Authority
Carewest
Catholic Social Services Community Care Program
Central Health Services
Comcare Health Services
Edmonton General Continuing Care Centre
Edmonton Home Services Ltd.
Foothills Continuing Care Centre
Gentiva Health Services (formerly named Olsten's)
Good Samaritan Society
Government of Alberta
Hardisty Nursing Home
Mount Royal Care Centre
Para-Med Home Health Care
Residential Aide Placement Services
Travois Holdings Ltd., Mayfair Care Centre
Venta Nursing Home
Victorian Order of Nurses
We Care Health Services

APPENDIX D: THE GENERAL SOCIAL SURVEY

Methodology

Analysis of the Cycle 11 of the 1996 General Social Survey on Social and Community Support was conducted in order to understand the extent of usage of public and private agencies compared to hiring paid workers directly. The case study compared the public - private mix in the financing and deliver of continuing care services in Alberta and Nova Scotia by conducting interviews with policy makers and agency representatives. This approach provided an overview of public and private agencies involved in the deliver of home care, however less is known about private contracting of self-employed individuals to deliver care. To help to fill this void, analysis of the 1996 General Social Survey was conducted as it has information on the source of assistance for specific activities of daily living. The results are presented in this Appendix. It must be cautioned however, that the results presented here are preliminary. A more intense data analysis is needed to understand the extent to which persons in need directly purchase services from individual providers.

Cycle 11 of the General Social Survey was chosen for obtaining a profile of Canadian caregivers and care receivers as its purpose is to understand the dynamic interplay between an individual's social network and the help received and provided (Statistics Canada, 1998a, p.11). The Social & Community Support Cycle, which was collected from February to December 1996, used a random-digit-dialing telephone methodology. The sample of households was stratified on the basis of geographic area. The survey instrument used during the telephone interview contained two parts. The first part was completed for each telephone number and gathered basic demographic information. A member of the household, 15 years of age or older, was then randomly selected to complete the second part of the survey. The second part of the survey collected more specific information in the areas of helping patterns. In total, 12,756 Canadians participated in the 1996 General Social Survey - an overall response rate of 85.3%. For a complete description of the methodology used for the 1996 General Social Survey, see *Public Use Micro data File Documentation and User's Guide* (Statistics Canada, 1998a). Because of the survey design to over-sample persons 65 and over-sample the Quebec population, the findings reported represent data weighted to the Canadian population.

This section will use a sub sample of persons aged 65 and older who receive assistance because of a temporarily difficult time or because of their long term health problem or disability. Descriptive analysis of the type of assistance received by the source of assistance (formal, informal support, or both) will be presented. Moreover, relationship of the caregiver to the respondent (care receiver) is analyzed for groupings of activities of daily living. This analysis will provide a snapshot of the number of respondents who received assistance from government and non-government agencies, from independent paid workers and from informal care providers.

Assistance with Specific Tasks by Overall Sources of Help

Table One presents data on elderly respondents who received assistance because of a long term health problem or disability or because of a temporary difficult time. Whether or not respondents received assistance with specific tasks is cross-tabulated by overall source of assistance.³

Table One: The percentage of elderly persons who have received assistance received by type of task and source of help.
(General Social Survey, 1996, Weighted to the Canadian Population)

	Help given to respondent was informal, formal or both informal and formal				
Type of Help	Informal	Formal	Both	Total	Cramer's V
House Cleaning	32% 154893	33% 158842	35% 171457	100% 485192	0.53
Meal Preparation	50% 124631	13% 31595	37% 91736	100% 247961	0.38
Grocery Shopping	50% 163141	6% 18649	44% 144649	100% 326438	0.58
Transportation	50% 152120	5% 16624	45% 138102	100% 306847	0.56
Banking/Bill Paying	53% 111017	2% 5072	45% 94161	100% 210250	0.46
Personal Care	29% 81780	28% 79594	43% 123801	100% 285175	0.4

*Cramer's V is based on a 2X4 table.

¹ The total represents the total number of persons who indicated that they received assistance with this task. The percentages are based on the number of persons who received assistance by the characteristic of the provider of the assistance (informal, formal, or both).

³ *Source of assistance:* The source of assistance is available for tasks where the person received help because of either long term health problems or disabilities **or** because of temporary difficult times. *Informal care* is defined as the performance of tasks by family and friends, without pay, that helps maintain or enhance people's independence. *Formal care* is defined as the performance of these same tasks by a paid employee/worker or through a governmental or non-governmental organization. *Mix of both informal and formal care* means that among the type of assistance received both formal and informal care were present.

The relatively high Cramer's V measure indicates a high association between the source of all assistance and whether or not the respondent received assistance in a particular area. There are two key findings which emerge from Table One. First, in all categories of assistance, with the exception of personal care and house cleaning, at least half of the respondents received assistance from only informal sources. Second, persons who received formal help only were more likely to receive assistance in the areas of house cleaning and personal care.

Specific Sources of Assistance with Tasks

Table Two and Figure One present data on the specific sources of assistance for activities of daily living. It is cautioned that the percentages reported here represent the proportion of sources of agencies identified by the respondent and not the amount of help that is received from each source.⁴ Among respondents who indicated receiving help in the area of house cleaning, meal preparation and home maintenance, 13% received help from a paid worker, 13% from a government organization and 9% from a non-government organization. In the area of shopping, transportation, and banking, informal sources (spouses/children, other relatives and neighbours and friends) were the overwhelming source of assistance. Among the 6% of formal sources in this area of assistance, data indicate that independent paid workers were twice as likely as government or non-government agencies to provide help. The involvement of government and non government was particularly evident in the area of personal care where over half of the sources of assistance were from agency personnel.

⁴ For example, 13% of the sources of help for home maintenance/meals /housecleaning were independent paid workers, 39% were spouses /children etc. It does not mean that paid workers provided 13% of the amount of help received.

Table Two: Source of assistance for meals, house cleaning or home maintenance, for shopping transportation and banking and for personal care among older persons who receive assistance because of a long term disability or a temporarily difficult time. (General Social Survey, 1996, weighted to the Canadian population.)

Types of Assistance						
Source of Assistance	Home Maintenance Meals/Housework		Shopping/Transportat ion/Banking		Personal Care	
	Percent	Frequency	Percent	Frequency	Percent	Frequency
Non Gov't Care	9.3%	7355	1.9%	953	28.7%	25640
Paid Worker	13.0%	10245	3.5%	1814	3.8%	3420
Gov't Organizations	12.8%	10110	0.5%	251	26.8%	23953
Spouse/Children	39.1%	30846	54.3%	27939	27.7%	24777
Other Relatives	8.7%	6868	17.0%	8761	2.0%	1783
Neighbour/Friend /Other	17.1%	13538	22.9%	11766	11.0%	9867
Total	100%	78962	100%	51484	100%	89440

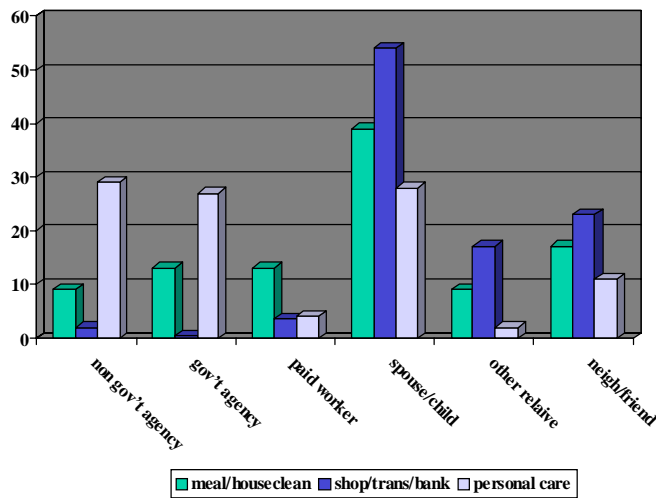
These data are presented in graphical form in figure one.

In summary the data indicate that the source of assistance varies by the type of assistance received. Even within formal sources of assistance, variations occurred by the type of assistance among formal sources. Paid workers were most likely to be involved in meal preparation, housecleaning and maintenance. For persons who received assistance with personal care, formal sources were in the majority, but these sources were typically from government or non-government organizations and not the independent paid workers. This finding is likely related to the eligibility criteria under public home care programs which generally favour providing support to assist with personal activities of daily living. More research is needed to understand whether it is the criteria of public programs which have the greatest impact on sources of assistance or whether the sources of assistance is primarily a function of the availability of formal or informal caregivers

Figure One: Source of assistance for meals, house cleaning or home maintenance, for shopping transportation and banking and for personal care among older persons who receive assistance because of a long term disability or a temporarily difficult time. (General Social Survey, 1996, weighted to the Canadian population.)

Type of assistance by source of help

General Social Survey, 1996



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