BC CARE PROVIDERS ASSOCIATION

Part 1

Sustainability and Innovation: Exploring Options For Improving BC's Continuing Care Sector

White Paper on Funding and Innovation

May 2016

Message from the CEO

According to Statistics Canada, for the first time in Canada's history we now have more seniors than youth under the age of 15. By 2036, over 25 percent of the population will also be over the age of 65. This highlights the critical need for us to explore new ideas and address the numerous challenges facing British Columbia's dynamic and ever-changing continuing care sector.

If we want to continue delivering top quality care for a growing number of seniors and other adults, many of whom are living with multiple chronic diseases, it is imperative we look at new innovative approaches. By doing so, we can also explore and adopt best practices in other regions as well develop our own made-in-BC solutions that will deliver better health outcomes for seniors.

The White Papers released today, which deal with sustainability and innovation in the continuing care sector, build on a longstanding BCCPA tradition of not only identifying problems, but also helping to resolve them. This can only be accomplished if we have established a true and effective collaboration with key partners such as the Ministry of Health and the Health Authorities.

The BCCPA, through its *Emerging Issues and Policy Committee*, has invested significant resources over the last year to research, draft and refine these White Papers. The first paper deals with issues around funding and financing of continuing care including approaches to improve sustainability. The second paper deals largely on innovative approaches focusing on five areas including exploring new care models for seniors, improving dementia care, use of technology as well as enhancing the safety and health of seniors.

The White Papers build on many of the key themes of the BCCPA Policy Paper released last year entitled *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC*. This was in direct response to a series of policy papers released by the Ministry of Health in February 2015.

Over the next four to six months, we will be actively seeking input from those receiving care, our members, key partners and a wide range of other stakeholders.

The feedback we gather during the consultation period will be shared and deliberated with over 100 individuals and organizations who we plan to invite to the inaugural *BC Continuing Care Collaborative* at the SFU Wosk Centre for Dialogue in Vancouver. The *Collaborative* will take place in September 2016 and we anticipate active involvement from everyone who intersects with BC's continuing care sector. This includes clinicians, health care workers, academics, care aides, labour organizations as well as a broad cross section of our membership.

The BCCPA is encouraging everyone to review the White Papers and consider which ideas, concepts and funding models would help foster a vibrant and sustainable continuing care sector while ensuring excellent seniors care moving forward. We look forward to hearing from you over the coming months.

Sincerely,

Daniel Fontaine
CEO, BC Care Providers Association

BC CARE PROVIDERS ASSOCIATION

Special Recognition

The BCCPA would like to acknowledge the following staff for their all of their hard work and dedication in helping to research and write this White Paper:

- Michael Kary, Director of Policy and Research, BCCPA
- Lara Croll, Policy Analyst, BCCPA

A number of member volunteers also contributed a significant number of hours in helping to develop this paper. They following are all members of the BCCPA Emerging Issues and Policy Committee:

- Sue Emmons, Chair – Northcrest Care Centre
- Elaine Price – Fraser Valley Care Centre Management
- Karen Baillie – Member – Menno Place
- Elissa Gamble – Member – Bayshore Home Health
- Al Jina – Member – Park Place Seniors Living
- Aly Devji – Member – Delta View Habilitation Centre and Life Enrichment Centres
- Tony Baena – BayBridge Senior Living

In addition, a special recognition to the following BCCPA staff for their support:

- Jesse Adamson, Communications Coordinator
- Diana Lim, Executive Assistant, Office of the CEO
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In closing, the BCCPA Board of Directors deserves special thanks for having agreed to support this initiative and dedicating the necessary resources to make it all happen.

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EXECUTIVE SUMMARY

With the ageing population, the issue of seniors, including seniors' health and the continuing care sector, has gained increased importance. Provincial/territorial (P/T) governments have also focused increasingly on seniors through the creation of various plans (i.e. BC Seniors Action Plan), as well as organizations and positions to better address seniors' issues. For example, in March 2014, British Columbia (BC) announced the appointment of Canada's first Seniors Advocate.

As part of this project, the BCCPA will be creating two separate white papers on the issues of sustainability and innovation in the continuing care sector. This first paper outlines issues around funding while the second outlines five potential areas (i.e. development of new care models, dementia, technology, senior's safety and health promotion) where BC could assist in advancing seniors' issues and improving the sustainability of the continuing care system.

The suggested areas also align well with those in the BC document Setting Priorities for the B.C. Health System, released February 2014, as well as touching on many of the themes outlined in the Ministry of Health Policy papers released in February 2015 (see Appendix A).[1]

The BC Ministry of Health papers identify various cross sector health strategic service priorities that will reposition the BC health system over the next five years to better meet both increasing and changing patterns of demand, including:

- Improving the effectiveness of primary, community care (including home support and residential care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use;
- To significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care;
- Significantly improving timely access to appropriate surgical treatments and procedures; and
- Establishing a coherent and sustainable approach to delivering rural health services.

In the process of developing this White Paper, the BC Ministry of Health in April 2016 announced it will be undertaking a review of staffing guidelines in government-funded long-term care homes for seniors after a report from the province's seniors advocate.[2] In particular, BC Heath Minister Terry Lake requested the Ministry undertake a review to examine how health authorities are funding seniors' homes, including looking

[1] On February 18, 2015 the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient centered care, health human resources, rural health, surgical services as well as primary and community care.
[2] Office of the Seniors Advocate. British Columbia Residential Care Facilities: Quick Facts Directory. January 2016. http://www.seniorsadvocatebc.ca/osa-reports/british-columbia-residential-care-facilities-quick-facts-directory/

at the care hours for different types of seniors, such as those facing dementia and other ailments.[3] Further details on this review will be forthcoming but the BCCPA, which generally supports such a review, hopes that some of the options outlined in this report may also assist the review process.

New funding approaches

As outlined in detail in the Quality-Innovation-Collaboration paper (2015) the BCCPA has advocated for a shift in funding from acute to home and community care, in particular recommending that the Performance Agreements between BC's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures - such as a minimum of 1% annually over a five-year period - to the continuing care sector. As seen most recently in Fraser Health Authority this may include a closure or reduction of acute care beds.[4]

The BCCPA believes that developing a systematic 5-year strategy to redirect funding from acute care could significantly help meet the current and future pressures facing the continuing care sector. It is also consistent with public opinion, as highlighted from the results of a 2015 BCCPA Commissioned Poll conducted by Insights West, which indicated that 62% of British Columbians believe that the health care system focuses too much on acute care and not on providing ongoing care needs (such as long term care or caring for the chronically ill elderly); while 68% believe the government does not provide adequate funding for residential care.

"The BCCPA believes that developing a systematic 5-year strategy to redirect funding from acute care could significantly help meet the current and future pressures facing the continuing care sector."

With respect to funding, this report, similar to the BCCPA *Seniors Care for A Change* (2014) document, recommends the BC government move towards a funding model that separates the bodies that fund, allocate funds, and regulate care homes from those that operate care homes. In order to ensure more appropriate and long term sustainable funding, this report also advocates that the BC government, in consultation with operators, develop a residential care funding model that accurately factors in increases to operating costs including wages, inflation, and overhead, as well as other areas including the acuity or complexity of residents in care.

With respect to home and community care funding models, the BCPCA advocates that the BC government and health authorities adhere to the core funding principles of timeliness, sustainability, equity and transparency. Furthermore, the BCCPA advocates that the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreements.

Along with the separation of funding and operations of residential care homes, the BCCPA encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts are provided for residential care

[3] Vancouver Sun. BC Health Minister Orders Review of Staffing Guidelines in Long-Term Care Homes for Seniors. April 7, 2016. http://vancouversun.com/news/local-news/b-c-health-minister-orders-review-of-staffing-guidelines-in-long-term-care-homes-for-seniors

[4] BCCPA. Closure of Acute Care Beds in Fraser Health a Step in Right Direction. February 19, 2016. Accessed at http://www.bccare.ca/closure-of-acute-care-beds-in-fraser-health-a-step-in-right-direction. As outlined, the Fraser Health Authority's has announced it will close 80 acute care beds in the region over the coming months. Those funds will be transferred into the community to support a growing number of seniors who require more appropriate care closer to home. A total of 400 new residential care beds are currently in the planning phase or under construction.

Likewise, the report also suggests that the BC government work towards the establishment of predictable, long-term funding models that are outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3- to 5-year period.

In addition to improved funding, it will be important to ensure that operators be appropriately consulted. Therefore, as a starting point, the BCCPA encourages the BC government to re-affirm the Managing Changing Need Policy as part of BC's Home and Community Care Policy Manual, or at minimum ensure that similar provisions exist elsewhere; and that in the long term the Managing Changing Need Policy or an updated policy be incorporated as part of the existing Community Care and Assisted Living Act and/or accompanying residential care regulations.

This report also identifies the importance of capital investment in continuing care and suggests that an industry, government and Health Authority committee or working group be established to study options around creating equitability and sustainability with regards to funding models and private sector investment in continuing care. Furthermore, in order to increase private sector investment and development of residential care capacity across the province, there should be fair and equitable capital cost coverage. Finally, this paper suggests that the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector.

As well as providing more predictable funding, the paper suggests that the federal government must also play a role by working with provinces and territories on the development of a new infrastructure fund for home and community care, as well as meeting the federal Liberal government's campaign commitments. The results of new funding models will also need to be carefully analyzed including use of activity and outcomes based funding, particularly reviewing any outcomes and/or results from Alberta's and Ontario's experimentation with these initiatives.

Alternative ways to fund home and community care also need to be explored, including using Social Finance arrangements; for example, Social Impact Bonds, and long-term care insurance. Finally, the paper also looks at reviewing existing co-payments for home and community care to better reflect actual costs of delivering care, and explore the use of vouchers.

OPTIONS FOR REVIEW / CONSIDERATION

Long-term sustainable funding:

1. The BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well adhering to the core principles of timeliness, sustainability, equity and transparency.

2. The BC Care Providers Association (BCCPA) encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts for home and community care are determined.

3. That the BC government, in order to remove the perception of a conflict of interest, consider moving towards a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

4. That the BC government, in consultation with operators, develop residential care funding models that accurately factor in increases to operating costs including wages, inflation, overhead as well as other areas such as increasing levels of acuity among residents and clients.

5. The BC government work towards establishing predictable long-term funding models by end of fiscal 2018, that are outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3 to 5 year period.

6. That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

New Federal Health Accord:

7. That the provincial government as part of any new federal Health Accord advocate that the following elements be included:

    - The establishment of an age-adjusted Canada Health Transfer that reallocates funding to provinces such as British Columbia with higher and growing portions of seniors;
    - New and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new continuing care models for residential care and home support; and
    - Meet commitments outlined in federal liberal platform including: a long term agreement on funding; invest $3 billion over the next four years to deliver more and better home care services for all Canadians; develop a pan-Canadian collaboration on health innovation; as well as improve access to necessary prescription medications, particularly for seniors.

Managing Changing Need:

8. The BC government clarify or re-affirm its position regarding Managing Changing Need and at minimum reintroduce the policy, or similar policy on an interim basis as part of BC's Home and Community Care (HCC) Policy Manual; and that in the long term the Managing Changing Need Policy or an updated policy be incorporated as part of the existing Community Care and Assisted Living Act and/or accompanying residential care regulations.

Capital Investment in Continuing Care:

9. To increase private sector investment and development of residential care capacity across the province, there should be fair and equitable return on the cost of capital.

10. That an industry, government and Health Authority committee or working group be established to study options around creating equitability and sustainability with regards to funding models and private sector investment in continuing care.

11. That the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector, thus allowing residential care homes to have the same tax free status as other health care facilities.

Activity and Outcome Based Funding:

12. That the BC Ministry of Health undertake a comprehensive review of the outcomes, results and lessons learned in the use of activity and outcome based funding for provision of home and community care, particularly reviewing any outcomes and/or results from Alberta and Ontario's experimentation with these initiatives.

Social Finance – new partnerships:

13. The BC government explore further the use of Social Finance arrangements including Social Impact Bonds to fund new potential investments within the continuing care sector.

Long-Term Care Insurance:

14. That provincial and/or federal governments explore reviewing further the concept of long-term care or autonomy insurance to address issues of an ageing population and increasing home and community care expenditures.

Review of co-payments for continuing care:

15. BC government explore existing co-payments for continuing care to better reflect actual costs of delivering care, and a resident's/client's ability to pay, while also ensuring seniors with lower incomes are protected.

Vouchers:

16. BC government explore the use of vouchers and whether they could be provided to seniors to pay for long-term care and/or assisted living services in lieu of government provision of such services.

ABOUT THE BCCPA

The BC Care Providers Association (BCCPA) has represented private and non-profit community care providers for over 30 years. We have over 150 residential care, home care and assisted living members across the province. Our members represent over one-third of all funded long-term care beds in B.C. – caring for over 25,000 seniors annually and creating more than 18,000 direct and indirect jobs across the province.

Previous BCCPA Policy Positions

In July 2014, the BCCPA released a report entitled *Seniors Care for a Change*. It included five key recommendations to help improve BC's continuing care sector:

1. Strengthen client payment and collection of outstanding debts;
2. Develop a new funding and accountability model for government's role in care, including separating the bodies that fund, allocate funds, and regulate care delivery from those that deliver care and operate care homes;
3. Implement a person-centred approach to care;
4. Reduce overlap with the investigation and inspection process; and
5. Streamline and standardize reporting and data collection.

The BCCPA report *Quality, Innovation, Collaboration: Strengthening Seniors Care Delivery in BC (QIC)* was released in September 2015. The report, which contained five recommendations to improve the quality and sustainability of seniors care in BC, recommended that the Ministry of Health:

1. Work with the health authorities, the BCCPA, and other stakeholders to better utilize existing excess capacity in the continuing care sector (including residential care and assisted living) to reduce Alternate Level of Care (ALC) beds and offset acute care pressures. This strategy includes the creation of a public registry to track vacant continuing beds and ALC beds.
2. Establish a *Continuing Care Collaborative* with the BCCPA to support the long-term sustainability of the home and community care sector and implement BCCPA and Ministry recommendations.
3. Review options for new service delivery models, particularly the Continuing Care Hub, to help reduce acute care congestion, as well as increase quality of care for frail elderly and those with chronic conditions and dementia.

4. Include a specific target in the Health Authority Performance Agreements to redirect 1% of acute care expenditures each year for five years to home and community care services for seniors and the development of more responsive care models.
5. Redefine the existing eligibility criteria for complex care and Assisted Living to allow seniors to remain in the most appropriate care setting longer, as suggested by BC's Seniors Advocate. This includes removing restrictions relating to prescribed Assisted Living services (currently two).[5]

The *Quality-Innovation-Collaboration* report also includes the BCCPA's Response to the Ministry of Health Policy Papers that were released in 2014. Here the BCCPA articulates the need for:

- Increased collaboration, including establishing a new BC Continuing Care Collaborative
- A review of funding lifts and Direct Care Hours in all health authority regions;
- A review of new funding models;
- Better dementia and palliative care, and
- Improvements in seniors' safety and quality of care.

[5] On March 7, 2016 the BC Ministry of Health announced new amendments that will be made to the *Community Care and Assisted Living Act* (CCALA), which will remove the limit around the number of prescribed services in assisted living. Likewise, additional amendments will also include increased regulatory oversight for assisted-living residences, particularly permitting the registrar to inspect a residence at any time to determine if there is a risk to the health and safety of a resident. (Source: Ministry of Health. Legislation supports seniors and vulnerable adults. Accessed at: https://news.gov.bc.ca/releases/2016HLTH0014-000338)

BACKGROUND

Seniors make up the fastest-growing age group in Canada; in 2010, the median age in Canada was 39.7 years, while it was only 26.2 years in 1971.[6] This trend is expected to continue for the next several decades; in 2010, an estimated 4.8 million Canadians were 65 years of age or older, but by 2036 this number is expected to increase to 10.4 million.

By 2038, BC's senior population will account for an estimated 24 to 27 per cent of the population, with the proportion of seniors nearly five per cent higher than the Canadian average. Furthermore, the Ministry of Health reports that the percentage of BC seniors over 80 years old will grow from 4.4% of the population in 2012 to 7.4% by 2036. At the same time, it is projected that the prevalence of chronic conditions for those over 80 may increase by 58 per cent over the next 25 years.

DID YOU KNOW: the Ministry of Health reports that the percentage of BC seniors over 80 years old will grow from 4.4% of the population in 2012 to 7.4% by 2036.

"The ageing of the population will put increased pressure on the health system, due in part to the greater prevalence of chronic diseases and mental health issues, including dementia."

The ageing of the population will put increased pressure on the health system, due in part to the greater prevalence of chronic diseases and mental health issues, including dementia. This is in part because health services tend to be used at higher rates as the population ages, with increased demand for home and residential care.[7] In BC, the total public cost of subsidies for residential care were approximately $1.7 billion in 2013, which amounts for 10 per cent of the provincial health budget. These costs are expected to increase to $2.7 billion by 2035.

In 2009, spending on seniors accounted for 54 per cent of the $9.2 billion spent on health care services in British Columbia. Total demand in BC for health care services by seniors is expected to increase by 41% over the next 10 years from population growth and ageing alone. In comparison, demand from the population under age 65 will only increase by 13%.[8]

Overall, British Columbia's health system is not prepared to meet the challenges of an ageing population. The health system in BC, much like the rest of Canada, is still largely acute care oriented and not optimally designed to provide care for those with ongoing care needs, such as chronically ill or frail elderly.

British Columbia's ageing population, however, presents significant opportunities to enhance the province's economic strength through capitalizing on care providers' entrepreneurial spirit and enhancing the efficiency, sustainability, and quality of our seniors' care system. In particular, as will be outlined in Part II of the White Paper, with among the highest average life expectancies and healthiest seniors' population in Canada, there is a real opportunity for BC to become an ageing centre of excellence.

The ageing population will put additional pressures on the health care system, particularly in dealing with mental health and chronic diseases. A large percentage (41%) of Canadian seniors, for example, are dealing

[6] Median age means that half of the population was older than that and half was younger.
[7] BC Stats. British Columbia Populations 2012-2036 – September 2012. Retrieved July 10, 2013 from: www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationProjections.aspx
[8] Blue Matrix. BC Ministry of Health Data.

with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning[9].

Over the next decade, federal spending on the elderly and health care will also increase by $10 billion and $7.4 billion, respectively. Together, that spending represents about half of all new federal spending anticipated between 2013-14 and 2017-18. Even without enriching any existing programs, spending on the elderly will take up almost a fifth of every dollar spent by Ottawa.

Seniors use several sectors of Canada's health care system more frequently than younger portions of the population, and utilize the system in different ways and with different intensity than other age groups. [10] In addition to using more hospital care than other segments of the population, seniors are high users of several other sectors of Canada's health care system. For example, in 2009-2010, 95% of people in residential care and 85% of people in hospital-based continuing care were 65 or older. Similarly, in that same year, 82% of home care clients were age 65 or older.[11]

Overall, it will be important for BC to work collaboratively with the federal government and other provinces and territories (P/Ts) to meet the challenges facing governments and seniors due to an ageing population. In the past, such collaboration has led to agreements such as in 2004, when F/P/T governments agreed on first-dollar coverage for home care services in several areas. In particular, under the *2004 10-Year Plan to Strengthen Health Care*, governments agreed to publicly fund two weeks of short-term acute home care after discharge from hospital; two weeks of short-term acute community mental health home care; and end-of-life care.[12]

CURRENT HOME AND COMMUNITY CARE FUNDING MODEL IN BC

Currently, the BC Ministry of Health allocates over $2 billion annually to five regional health authorities to deliver Home and Community Care (HCC) to more than 100,000 clients. While the Ministry provides overall funding and stewardship, the five regional health authorities directly deliver programs and contract with private for-profit and non-profit agencies to provide services (see Table 1 below for definitions of services).

The health authorities meanwhile are responsible for: delivering programs that are consistent with home and community care policies and standards; ensuring operational policies and procedures are in place; planning and monitoring services at a regional level; and reporting to the ministry on their

[9] Health Council of Canada. Seniors in Need, Caregivers in Distress (March 2012). Accessed at: http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%202012/HCC_HomeCare_2d.ashx
[10] Canadian Institute for Health Information. Health Care in Canada, 2011: A Focus on Seniors and Aging. Accessed at: https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf
[11] Ibid.
[12] 2004 10 Year Plan to Strengthen Health Care. Accessed at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

performance.[13] The authorities develop their budget from the allocation provided and, in part, based on ministry's priorities as outlined in the Government Letters of Expectation.

In addition to the health authorities, a number of non-government operators deliver residential care, assisted living, and other services to British Columbia residents who pay directly for the services. These operators are not publicly subsidized and the users of the services pay the full costs. Within some home and community care services, clients pay a portion of the costs.

A general overview of the continuing care system in British Columbia is provided in the Table 1 below (see Appendix B for further information).

Table 1: Types of Home and Community Care Support	
Type of Support	**Services / Supports Received**
Home Support	Home support services are direct care services provided by community health workers to clients who require personal assistance with activities of daily living, such as mobility, nutrition, lifts and transfers, bathing and dressing, cueing, grooming, and toileting, as well as some safety maintenance activities where appropriate (e.g. clean-up, laundry of soiled bedding or clothing, and meal preparation). In addition, community health workers may perform some specific nursing and rehabilitation tasks that have been delegated by health care professionals.
Choice in Supports for Independent Living	Clients receive funds, either directly or through a client support group, to purchase and manage their own home support services.
Home Health Care	Professional health services delivered in the home such as nursing care, physiotherapy, and occupational therapy.
Adult Day centres	Supportive group programs for seniors and adults with disabilities living at home. May include bathing programs, personal care, social activities, meals, and transportation.
Caregiver relief / respite	Temporary relief to informal caregivers in either the client's home, or the client may be admitted temporarily to a care home.
Assisted Living	Publicly subsidized apartments with support services for frail seniors and people with disabilities. Housing, meals, laundry, housekeeping, and some personal care services are provided. Nursing care is not provided but is a 24-hour emergency response system in place.
Residential care home	24-hour professional nursing care and supervision in a care home.
Family Care Homes	Single-family residences that provide supportive accommodation for up to two residents.

Current Costs of Residential Care in British Columbia

Under Residential Care arrangements, seniors pay up to 80% of their after tax income on a monthly basis to cover the cost of housing and hospitality services including meals, routine laundry and housekeeping, subject to a minimum and maximum monthly rate. The monthly client rate for long-term residential care services is determined as follows:

[13] BC Auditor General Report. Home and Community Care Services: Meeting Needs and Preparing for the Future. October 2008. Accessed at: http://www.bcauditor.com/pubs/2008/report7/home-and-community-care-services-meeting-needs-and-prepar

- If your income is less than $19,500 per year (Formula A):
    - Annual after tax income is set to less than $3,900 ($325 multiplied by 12), divided by 12.
- If your income is equal to or greater than $19,500 per year (Formula B):
    - Annual after tax income is multiplied by 80%, and divided by 12.

The minimum monthly rate for a client receiving family care home or residential care services in 2015 is $991.20 per month. The minimum rate is adjusted annually based on changes to the Old Age Security/Guaranteed Income Supplement rate as of July 1st of the previous year. The minimum monthly rate for spouses receiving residential care services and sharing a room, where the couple is in receipt of the Guaranteed Income Supplement at the married rate, for 2015 is $736.00 per month per person. The maximum monthly rate for a client receiving family care home or residential care services is $3,157.50 per month. The maximum client rate is adjusted annually based on changes to Consumer Price Index.

DID YOU KNOW: *In 2015* the maximum monthly rate for a client receiving family care home or residential care services is $3,157.50 per month.

DID YOU KNOW: The minimum monthly rate for a client receiving family care home or residential care services in 2015 is $991.20 per month.

Although it is difficult to project future long-term care expenditures, using CIHI data one can attempt to derive future cost projections for "other institutions" which includes, among other things, care homes, registered nursing homes for the aged, the chronically ill or disabled, or to treat alcohol and drug problems. The largest or most significant portion of this funding would be towards residential care.

Using CIHI data for 2012, BC spent approximately $1.88 billion on other institutions ($1.12 billion government, $738 million private / out of pocket). Provinces/ territories are responsible for close to 71 per cent of all "other institutions expenditures" and the private sector (including direct payments by Canadians) close to 29 per cent. "Other institutions" expenditures in Canada have increased at an annual real rate of 4.4 per cent—on top of inflation—over the past 15 years, from $10.1 billion of constant 2012 dollars in 1997 to $22.4 billion in 2012.[14]

[14] Sustainability of the Canadian Health Care System and Impact of the 2014 Revision to the Canada Health Transfer. September 2013. Canadian Institute of Actuaries. Stéphane Levert. Accessed at: http://www.cia-ica.ca/docs/default-source/2013/213075e.pdf

British Columbia Projected "Other Institutions Expenditures," 2012 to 2037, Base Scenario (millions of constant 2012 dollars) – Table 2

Year	Millions of constant 2012 dollars
2012	$1,124
2013	$1,164
2014	$1,204
2015	$1,246
2016	$1,289
2017	$1,332
2018	$1,378
2019	$1,424
2020	$1,471
2021	$1,524
2022	$1,581
2023	$1,642
2024	$1,706
2025	$1,773
2026	$1,849
2027	$1,932
2028	$2,021
2029	$2,114
2030	$2,208
2031	$2,305
2032	$2,421
2033	$2,536
2034	$2,651
2035	$2,767
2036	$2,880
2037	$2,997

Source: Sustainability of the Canadian Health Care System and Impact of the 2014 Revision to the Canada Health Transfer. Canadian Institute of Actuaries. Stephan Levert. September 2014. Accessed at: http://www.cia-ica.ca/docs/default-source/2013/213075e.pdf

FUNDING PRINCIPLES

In British Columbia, continuing care providers consistently deliver high quality care for seniors. Yet despite the fact that new entrants into home and community care have much higher levels of acuity than in previous years, and are increasingly living with multiple chronic conditions, while funding lifts for residents/clients and operators are often less than collective agreement increases. Furthermore, cost of living increases are not fully recognizing inflationary pressures and/or enhanced service delivery requirements.

"… new entrants into home and community care have much higher levels of acuity than in previous years, and are increasingly living with multiple chronic conditions, while funding lifts for residents/clients and operators are often less than collective agreement increases."

Another major issue is that some residential care provider members are not being advised of their annual fiscal year funding increases until well into the fiscal year, while many of BCCPA contracted home care members have not seen funding increases for several years. This adds undue financial stress and operational challenges for BCCPA members, who are unaware of what their final operating budgets are until well into or even after the fiscal year in which the services were delivered.

Another major issue is the discrepancies with respect to funding of direct care hours for seniors with similar medical conditions, which vary widely between Health Authorities, as well as within an individual Health Authority. With such disparities, it makes it impossible to provide equal and consistent levels of care, leaving some clients and residents at a disadvantage.

In light of these concerns, the BCCPA has endorsed the following funding principles at its Annual General Meeting (see the box below and Appendix C).

BCCPA KEY FUNDING PRINCIPLES

Timeliness:

- Health Authorities will aim to provide care providers in writing with their funding notice prior to March 31st but no later than 90 days after the start of the fiscal year on April 1st.

Fiscal Sustainability:

- Contracted care providers are provided the necessary funding to cover identified year-over-year costs related to inflation in order to ensure they remain financially whole.

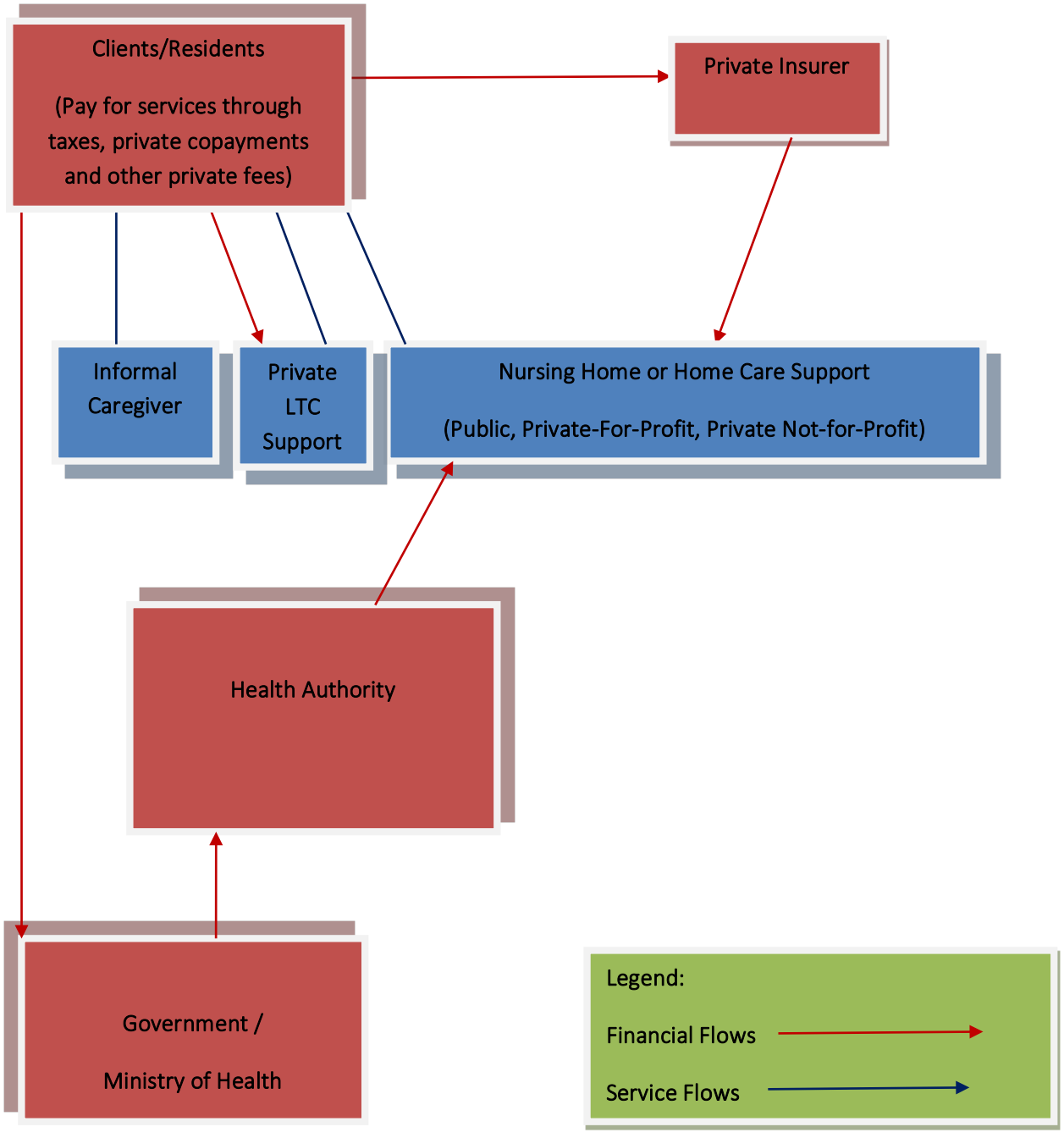
Equity:

- The calculation of funding lifts and direct care hours is consistent within and across health authorities.

Communication and Transparency:

- Contracted service providers are provided with timely and appropriate communication regarding any significant issue related to their funding relationship with the health authority;
- The methodology used to calculate annual funding lifts will be shared openly with care providers.

Figure 1: Current Funding System for LTC in British Columbia



As a result, the BCCPA encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates.

OPTION 1 FOR CONSIDERATION:
The BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well as adhering to the core principles of timeliness, sustainability, equity and transparency.

Funding Lifts by Health Authority

In order to develop a province-wide methodology to determine how base funding and annual funding increases are calculated for contracted service care providers, the BCCPA met with Health Authority representatives, namely Chief Financial Officers, to obtain information on actual 2014/15 funding lifts by Health Authority.

After contacting the Chief Financial Officers and receiving follow-up information, the BCCPA has developed a table (see Appendix H) which shows funding lift percentage increases to residential care operators for 2014/15 along with various cost increases facing operators including Medical Service Plan (MSP), Municipal Pension Plan (MPP), CPP, utilities, etc.

As demonstrated in Appendix H, there is some variation between the funding lifts provided to non-government care operations among health authorities. Specifically, the funding lifts for 2014/15 range from 0% in Interior Health to 1.18% in Island Health. The actual funding lifts for residential care for 2014/15 were: 0% for Interior Health; 0.65% for Vancouver Coastal; 0.39% for Fraser Health; and 1.18% for Vancouver Island. [15]

These funding increases, however, did not cover many of the cost pressures that non-government care operators identified being faced with, including:

- Medical Services Plan (3.98% increase for 2014/15)
- Municipal Pension Plan (1.4% increase)
- Canadian Pension Plan (2.1% increase)
- Non-compensation support costs (8.42% increase), including medical supplies, food and dietary, housekeeping, laundry, and plan services
- Utilities (4.0% increase) including gas, electricity and water
- Insurance (between 1.5% and 1.83% increase)
- Wages (between 1% to 2% increase) includes contracted workers
- Other Costs (7.18% increase) including extended benefits and EI

The Health Authorities identified that their funding lifts covered only these specific identified costs:

- Vancouver Coastal: MSP, MPP, non-compensation support and other costs;
- Fraser Health: non-compensation support costs and utilities;

[15] While these funding shortfalls are specific to residential care, it should be noted that contracted Home Support providers experienced similar funding shortfalls in 2014/15.

- Vancouver Island Health: non-compensation support costs and other costs; and
- Interior Health: no costs identified.

This demonstrates the insufficiency of current funding lifts, and the inadequacy of the current lack of a consistent, province wide mechanism to determine funding lifts as well as the need for further progress to ensure that residential care operators are appropriately funded.

> "Given the fiscal challenges facing care operators, the BCCPA will continue to advocate for the need to address existing funding pressures."

Given the fiscal challenges facing care operators, the BCCPA will continue to advocate for the need to address existing funding pressures. This is an issue that the Continuing Care Collaborative, once established, could also address. In the meantime, the BCCPA will also attempt to develop an annual funding lift comparison to see if any trends and/or changes develop over time.

OPTION 2 FOR CONSIDERATION:

The BC Care Providers Association (BCCPA) encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts provided for home and community care are determined.

Direct Care Hours

> "… there are significant disparities that exist in British Columbia (BC) with respect to Direct Care Hours (DCH) among care homes within and between Health Authorities and such disparities makes it difficult to provide equal and consistent levels of care leaving some residents at a disadvantage over others."

Increases in funding lifts should also reflect, where necessary any increased requirements with respect to direct care hours (DCH) for seniors living in residential care. Overall there are significant disparities exist in British Columbia (BC) with respect to Direct Care Hours (DCH) among care homes within and between Health Authorities and such disparities makes it difficult to provide equal and consistent levels of care leaving some residents at a disadvantage over others. As also outlined also in Appendix D the BCCPA will review a motion with regards to issue of DCH at its 2016 AGM, including that:

- Any increases in DCH requirements be fully funded by the Health Authorities;
- Where feasible, BC move towards a standard of 3.36 hours of care per resident per day and that any necessary staffing increases to meet this requirement be fully funded by Health Authorities and/or Ministry of Health; and
- There should be a standard definition for DCH that includes RNs, LPNs, Care Aides as well as other allied health professionals and activity staff, and that clinical support provided by Directors of Care (DOC), assistant DOC, and clinical coordinators be included consistently in the calculation of DCH. Separation of Funding and Operations.

In February 2009, the BC Ministry of Health issued a directive to health authorities requiring each of them to create a three-year plan to address a number of issues, including details of how they could provide 3.36 DCH per resident per day in their plans. The health authorities responded to the Ministry as follows:

- Fraser Health would need to invest an additional $79 million in staffing to achieve the guideline (24 per cent increase in staffing costs);
- Interior Health estimated it would cost $39 million to achieve guideline;
- Norther Health would require an additional $11.6 million to meet the guideline (increase staffing costs for registered nurses, licensed practical nurses and residential care attendants by 25 per cent);
- Vancouver Coastal estimated it would cost approximately $57 million to achieve the guideline and that it could reallocate $6.7 million to help fund this; and
- Vancouver Island could not fund increased staffing by reallocating its resources and that it would not be able to achieve the guideline without additional resources. [16]

Shortly after the Ministry's directive, additional resources were made available as the new residential care rate structure took effect in January 2010. It was projected to generate about $53.7 million in extra revenue every year after its second year of implementation. The Ministry informed health authorities that it expected them to invest additional revenue back into delivery of care and prioritize increasing DCH. [17]

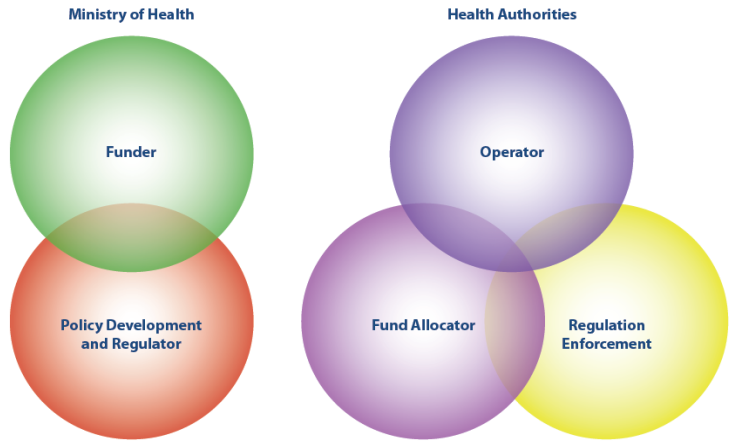
Separation of funding and operation of care homes

The current model of care operations has been in place for over a decade, since the Health Authorities restructured it in 2001. No substantial review has been conducted on how private care homes are funded and regulated. At present, the model has the health authorities as funder, regulator, and operator. The Ministry of Health provides the funding, and the health authorities allocate the funding and regulate both private and non-profit care homes. That is, health authorities compete for resources with private industries since they are operators of care homes, yet at the same time also regulate and allocate funds to themselves and to private care homes. The overlap in responsibilities could skew the industry and as such reduce market efficiency. Figure 2 below shows the current, overlapping model that separate the bodies that fund, allocate funds, and regulate care homes, from those that operate care homes.

[16] Ombudsperson. The Best of Care: Getting It Right for Seniors in British Columbia. Part 2. February 2012. Accessed at https://www.bcombudsperson.ca/seniors/seniors-care-investigation/seniors-report-part-two

[17] Ibid.

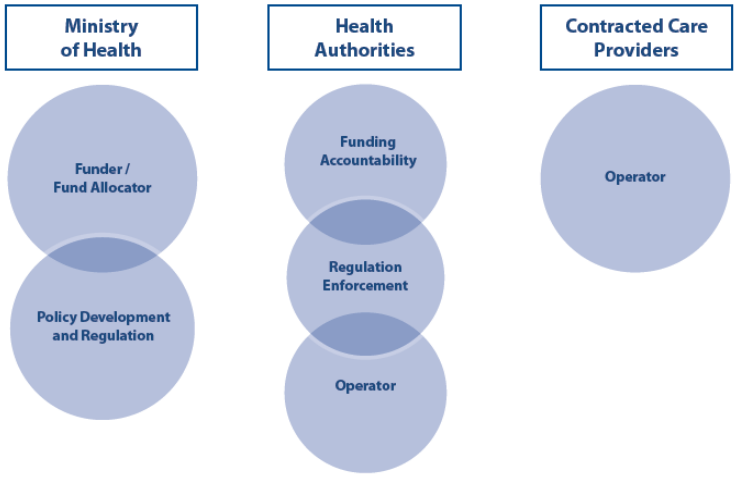
Figure 2: Current Model of Government's Role in Care



Overall government can provide cleaner lines of responsibility and accountability to taxpayers and residents by separating the bodies that regulate care homes and that provide and allocate funds from those that operate them. If the Ministry of Health were to provide and allocate funds while the health authorities and private and non-profit organizations operate care homes, then possible conflicts of interest could be minimized. This will increase transparency and competitiveness, and in doing so, improve the efficiency of the sector without any reduction in the quality of care. The diagram below shows new model with responsibilities no longer overlapping. although this new model may not perfectly level the playing field between health authority and private care homes, it could help clarify the lines of accountability.

> "If the Ministry of Health were to provide and allocate funds while the health authorities and private and non-profit organizations operate care homes, then possible conflicts of interest could be minimized."

Figure 3: Proposed Model Separating Roles of Government and Care Providers



OPTION 3 FOR CONSIDERATION:

That the BC government, in order to remove the perception of a conflict of interest, consider moving towards a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

SUSTAINABLE LONG-TERM FUNDING

> "…one group facing major fiscal pressures are those that deliver care and operate care homes."

As outlined in the BC Care Providers Association (BCCPA) 2015 budget submission, one group facing major fiscal pressures are those that deliver care and operate care homes. The allocated budgets or per diem rates of these non-government operators are increasing only marginally, if at all. This is despite an ageing population and increasing levels of acuity.[18] Furthermore, according to the BC Ministry of Health the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.[19]

Along with ageing, there are other various cost drivers in the health system including inflation (which accounts for about 2% in annual growth), followed by utilization of services, infrastructure maintenance and replacement.[20] To meet the needs of residential care operators and improve the sustainability of the continuing care system, the first priority must be the establishment of a predictable, long-term funding model that is included in any contract arrangements with the health authorities. Ideally, this would include more long-term budgeting with increases to per diem client rates outlined over a 3 to 5 year period. These rates should accurately factor in increases to operating costs including wages, inflation, and overhead, as well as other areas such as increasing levels of acuity among residents.

> "In BC, the shift to complex care delivery due to new investments in home care has resulted in a significant increase in the acuity level of seniors in residential care. Increases in funding, however, have not matched this rising acuity."

In BC, the shift to complex care delivery due to new investments in home care has resulted in a significant increase in the acuity level of seniors in residential care. Increases in funding, however, have not matched this rising acuity. For example, similar to BC, a large percentage of Canadian seniors (over 40%), are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are also experiencing a decline in physical and/or cognitive functioning.[21]

Despite increasing levels of acuity and multiple chronic conditions, funding is often less than collective agreement increases or cost of living increases, as health authorities rarely recognize inflationary pressures. One such example of this pressure is new and increasing Medical Service Plan (MSP) fees that are placing increased fiscal burdens on residential care operators and diverting funding away from direct resident care.

[18] Health Council of Canada Report – Seniors in Need, Caregivers in Distress (April 2012). Accessed at: http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

[19] Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf

[20] Ibid.

[21] Health Council of Canada. Seniors in Need, Caregivers in Distress (March 2012). Accessed at: http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%202012/HCC_HomeCare_2d.ashx

As a result of these deficiencies, funding shortfalls in the continuing care sector increase year after year. These funding shortfalls also come at a time when there are calls from the public and the families of those in care to provide an even higher level of service for their loved ones.

While BCCPA members deliver the best care possible and creatively find ways to get by with the resources available through government funding, shortfalls are ultimately to the detriment of seniors in care. This system of having care homes operate at a financial disadvantage is inefficient and unsustainable. An efficient and sustainable system requires collective agreements to be fully funded and other care costs fairly compensated. Accordingly, we advocate that government ensure funding matches the cost of delivering complex care. In addition, this may also require looking at new funding models to ensure continuing care operators receive appropriate funds and that residents receive the care they need.

The BCCPA encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. In particular, as outlined in the 2012 Ombudsperson report, the Ministry of Health should also work with health authorities to conduct an evaluation to determine whether residential care budgets in each health authority are sufficient to meet the current needs of its population.

Finally, the BCCPA advocates that Health Authorities provide greater transparency with respect to how the funding lifts provided for residential care are determined. This includes outlining in detail how changes are derived as part of any funding model, as well as involving operators in the process so they are prepared well in advance of any changes.

Escalating wage pressures

While the Health Employers Association of British Columbia (HEABC) is responsible for negotiating collective agreements on behalf of the provincial government, these agreements can also significantly impact the operating costs of care providers. In particular, care provider members, both those included in the master collective agreement and those not, are required to pay completive wages rates, which are determined by the master collective agreement.

These collective agreements, including new labour wage increases, place increased fiscal and labour market cost pressures on care operators. As such, it is important that the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

OPTION 4 FOR CONSIDERATION:

That the BC government, in consultation with operators, develop home and community care funding models that accurately factor in increases to operating costs including wages, inflation, overhead as well as other areas such as increasing levels of acuity among residents and clients.

OPTION 5 FOR CONSIDERATION:

The BC government work towards the establishment of a long-term predictable funding model by end of fiscal 2018 that is outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3 to 5 year period.

OPTION 6 FOR CONSIDERATION:

That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

REALLOCATING INVESTMENTS FROM ACUTE TO HOME AND COMMUNITY CARE

On February 18, 2015 the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient centered care, health human resources, rural health, surgical services as well as primary and community care. The most relevant of the papers with respect to the continuing care sector and seniors was the report on primary and community care.

One of the major themes noted in this paper is that existing expenditures will be protected, while appropriate reallocations from the acute to the community services sector must become part of health authority planning going forward, and a majority of new net funding must be assigned to developing primary and community services.

In the long run, investing in continuing care makes financial sense. According to the Canadian Life and Health Insurance Association (CLHIA), it costs $842 per day for a hospital bed, versus only $126 per day for a long-term care bed. If ALC patients were moved to more appropriate care settings (from hospital to long-term care) CLHIA notes this could save the Canadian health care system about $1.4 billion a year.[22]

DID YOU KNOW: According to the Canadian Life and Health Insurance Association (CLHIA), it costs $842 per day for a hospital bed, versus only $126 per day for a long-term care bed.

Proportionate cost savings could be made in British Columbia, given that in BC the cost of treating a senior in hospital ranges from $825 to $1,968 per day, whereas the cost of residential care is approximately $200 per day.[23] As outlined in the BCCPA's *Quality-Innovation -Collaboration* report, assuming 50% of ALC days could be reduced by caring for patients in residential care homes (average daily cost of $200) instead of in a hospital (average daily cost of $1,200) it could generate over $200 million in annual cost savings ($203.6M). These savings in turn could also be used to reduce wait times for existing elective surgeries.

[22] Improving the accessibility, quality and sustainability of long-term care in Canada. CLHIA Report on Long-Term Care Policy. June 2012.
[23] Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf

Based on initial estimates $203.6M in acute care savings could potentially fund the following surgeries:

- 13,196 Additional hip replacements; or
- 17,085 Additional knee replacements; or
- 65,471 Additional cataract surgeries; or
- 9,690 Additional Cardiac Bypass Graft (CABG) surgeries.

Of particular concern in jurisdictions across Canada, including British Columbia, is that the number of assisted living units and residential care beds has failed to keep up with the ageing population, leaving hundreds of elderly waiting months for government subsidized beds.

To deal with such concerns, the Canadian Medical Association (CMA) recently advocated the federal government allocate $2.3 billion over a five-year period in the next long-term infrastructure plan for the construction, renovation and retrofitting of long-term care homes. As outlined in the CMA paper, long-term care homes also include assisted living units and other types of innovative residential models that ensure residents are in the care setting most appropriate to their needs.[24]

As part of any new dedicated infrastructure fund it would be important that all homes, including non-profit organizations, have an opportunity to access any new funding. Currently non-profit homes do not have the same access or opportunities that other providers do.

The One Per Cent Solution

As outlined in the *Quality-Innovation-Collaboration* paper (2015) the BCCPA advocates for a shift in resources from acute to home and community care. In particular it recommends that that the Performance Agreements between BC's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1% annually over a five year period to the home and community care sector. A thorough public reporting on the additional services provided to seniors on an annualized basis as result of this investment should also be considered.

> "… BC's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1% annually over a five year period to the home and community care sector."

The BCCPA believes that developing a systematic 5 year strategy to redirect funding from acute care could significantly help meet the current and future pressures facing the continuing care sector. It is also consistent with public opinion. For example, results from a 2015 BCCPA Commissioned Poll, conducted by Insights West, indicate that British Columbians also believe government should increase funding for long-term care. In particular, it found that:

- 62% believe that the health care system focuses too much on acute care and not on providing ongoing care needs, such as long term care or caring for the chronically ill elderly;
- 68% believe that the government does not provide adequate funding for residential care; and

[24] CMA Submission: The Need for Health Infrastructure in Canada. March 18, 2013. http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Submissions/2013/Health-Infrastructure_en.pdf

- 84% believe that as seniors enter residential care homes with increased acuity or medical complexity, government funding should increase to meet these care needs.[25]

National Collaboration on Seniors

As part of the Council of the Federation's Health Care Innovation Working Group, provinces and territories (P/Ts) are also looking at advancing seniors care as a priority issue, focusing on areas such as home care over long-term care homes. In particular, at their July 2013 meeting, along with examining dementia, Premiers advocated that the Seniors Working Group look at successful efforts to improve ageing in place for seniors, and identify two to three innovative models for P/Ts to consider adopting.[26]

There is a definite role for the federal government to play with respect to seniors' issues including health, housing, and income supports, to name a few. While P/Ts through the Council of the Federation's Health Care Innovation working Group have indicated a willingness to work together, there has been less interest from the federal government. Since the 2004, 10 *Year Plan to Strengthen Health Care*, and with the election of the federal Conservative Party in 2006, the federal government played a very minimal role with respect to health, largely emphasizing that it is a provincial responsibility.

More recently, the federal Liberal government has indicated that it will be taking a more active role in health care. This was seen in the mandate letter sent in November 2015 from the Prime Minister to Canada's health Minister outlining some of the key priorities of the new federal government with respect to health including negotiation of a new multi-year health accord with commitments for better home care services, as well as better access to prescription medications and quality mental health.[27]

> "There is a definite role for the federal government to play with respect to senior's issues including health, housing, and income supports..."

One drawback of inviting federal government involvement or assistance is that it could also lead to greater federal intrusion into areas that are primarily P/T responsibilities, including health or housing. The federal government, for example, has not been resistant to encroach on P/T areas of responsibility when it suits their agenda. Examples of these include the unilateral federal announcement of Patient Wait Time Guarantees in 2007 or the initial introduction of the Canada Jobs Grant.

One way for the federal government, however, to assist provinces particularly around efforts to renew and, where necessary, replace existing infrastructure and increase capacity in long term care, is to revive the historic role that the Canadian Mortgage and Housing Corporation (CMHC) previously had in the sector. CMHC, for example, can help reduce the risks around financing, and ensuring that funding is loaned to care providers to better support the delivery of care and not diverted to interest payments.

Along with a role in expanding capacity within the continuing care sector, there are a number of potential issues P/Ts could work with the federal government on in regards to seniors. As outlined in a recent document on current and emerging issues facing older Canadians, key areas of potential collaboration could include:

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[25] The results included from this poll are based on an online study conducted by Insights West among a representative sample of 814 British Columbian adults. The data has been statistically weighted according to Canadian census figures for British Columbia for age, gender and region. Results have a margin of error of ±3.5 percentage points, 19 times out of 20.

[26] "Canada's Provinces and Territories Realize Real Savings in Healthcare through Collaboration". Council of the Federation. July 26, 2013.

27 Ottawa Citizen. Mark Kennedy. Tobacco packaging, trans fats to be part of government's 'activist' health agenda. November 19, 2015. Accessed at: http://ottawacitizen.com/news/national/tobacco-packaging-eliminating-trans-fats-to-be-part-of-governments-activist-health-agenda

- Ageing in Place (i.e. Home and Community Care, Age Friendly Cities / Communities, Home Care Services, Ageing at Home Technology and Housing);
- Support to Caregivers (i.e. informal and family care givers, Financial and Psychological Support);
- Ageing Workforce (i.e. Pensions, Retirement, Workforce Participation, Incomes);
- Healthcare Sustainability (i.e. funding for health, long-term care insurance)
- Ageism and Discrimination (i.e. Rights and Responsibilities);
- Keeping Older People Connected and Active (i.e. Falls Prevention, Mobility, Health Promotion, Active Ageing, Volunteering, Life Long Learning, Technology, Intergenerational Programs and Preventing Social Isolation); and
- Preventing Elder Abuse.[28]

The idea of a National Strategy for Seniors has also been proposed by various stakeholders including the Canadian Medical Association. In their 2013 National Report Card on health, it found that:

- 93% of Canadians believe that Canada needs a pan-Canadian strategy for seniors health care at home, hospitals, hospices and long-term care homes;
- 89% believe a national strategy for seniors should involve federal, provincial, territorial and municipal levels of government;
- 78% believe federal government has an important role in developing the strategy; and
- 63% believe home and community care should be the most important focus for governments when improving health care quality for senior citizens.[29]

DID YOU KNOW: 93% of Canadians believe that Canada needs a pan-Canadian strategy for seniors health care at home, hospitals, hospices and long-term care homes.

The BCCPA supports a federal government working collaboratively with provinces, including in particular to establish a new health accord. As part of any new health accord, the BCCPA has advocated for the establishment of an age-adjusted Canada Health Transfer (CHT) that reallocates funding to provinces, such as British Columbia, with higher and growing portions of seniors; as well as new and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new continuing care models for residential care and home care.

The BCCPA believes that changes to the CHT along with new investments would help assist in meeting some of the capacity challenges facing the continuing care sector, as well as improving seniors care overall. In 2012, it was reported that 461,000 Canadians were not getting the home care they thought they required.[30] Wait times for access to long-term care in Canada also ranged anywhere from 27 to 230 days.[31] Other key concerns facing the sector include health human resource challenges – particularly the shortage of geriatricians and other health care providers.

A new health accord should also meet the federal Liberal commitments outlined during the last election, including a long term agreement on funding; investments of $3 billion over next four years to deliver more

[28] Current and Emerging Issues Facing Older Canadians. International Federation on Ageing. March 30, 2012. Accessed at: http://www.ifa-fiv.org/wp-content/uploads/2012/12/current-and-emerging-issues-facing-older-canadians-final-report-30-march-2012.pdf
[29] CMA National Report Card on health. 2013. Accessed at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php
[30] Canadian Medical Association. Doctors to leaders: Canadians want a Seniors Care Plan in election. August 2, 2015. Accessed at: http://www.newswire.ca/news-releases/doctors-to-leaders-canadians-want-a-seniors-care-plan-in-election-520419582.html
[31] Ibid.

and better home care services for Canadians; a pan-Canadian collaboration on health innovation; as well as improving access to necessary prescription medications, particularly for seniors.

OPTION 7 FOR CONSIDERATION:

That the provincial government as part of any new federal Health Accord advocate that the following elements be included:

- The establishment of an age-adjusted Canada Health Transfer that reallocates funding to provinces such as British Columbia with higher and growing portions of seniors;
- New and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new continuing care models for residential care and home support; and
- Meet commitments outlined in federal liberal platform including a long term agreement on funding; invest $3 billion over the next four years to deliver more and better home care services for all Canadians; develop a pan-Canadian collaboration on health innovation; as well as improve access to necessary prescription medications, particularly for seniors.

Provincial and Municipal Collaboration

Overall, the majority of the options for consideration outlined in this White Paper deal with provincial actions. There are, however, some areas where a greater municipal role could be advantageous, such as discussed later in this paper in the section on capital investment - waiving property taxes for care home operators.

As outlined in Part II of the White Paper, ensuring residential care homes are integrated appropriately into age friendly or dementia friendly communities may also require addressing some of the issues regarding municipal zoning requirements. In a number of cases, requiring approval for the development of a residential care home can be hampered by municipalities, particularly by their strict zoning requirements.

Another potential role for municipalities is to assist with capital development or related costs to support the creation of care homes and/or services for seniors. One such example is seen in the municipality of Arborg, Manitoba where, after lobbying the province unsuccessfully for several years, the Arborg Seniors Housing Corporation decided to attempt to raise money to build one themselves. Arborg has since submitted a plan to build an 80-bed care home that would be attached to the existing assisted living and senior housing building.[32] The actions taken by these municipalities are an attempt to meet the greater demand for senior's care, as the Manitoba Centre for Health Policy projects it will need to add 5,100 personal care home beds in the next twenty years to meet the needs of the baby boom generation. That's an increase of 51 per cent on the 9,891 beds currently in Manitoba.[33]

In BC, municipalities working jointly with the provincial government and the sector could also work together to determine what the future projected needs are for long-term care beds, and then develop appropriate strategies to better meet these targets. Some of these strategies could potentially include development of new care models (i.e. Continuing Care Hub) as explored in Part II.

[32] Care home wait times have Manitoba towns trying to build their own. Bridget Forbes. CBC News: March 8, ,2016. Accessed at: http://www.cbc.ca/news/canada/manitoba/care-home-wait-times-have-manitoba-towns-trying-to-build-their-own-1.3482266

[33] Projecting Personal Care Home Bed Equivalent Needs in Manitoba through 2036. Manitoba Centre for Health Policy. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

MANAGING CHANGING NEED

In addition to stable and predictable funding, it will be important to ensure that existing operators are consulted well in advance of any potential changes to their care homes.

An example of such an approach was the 'Managing Changing Need' policy outlined in an earlier version of BC's Home and Community Care Policy Manual (see below). The policy applied to the termination of contracts and preferential consideration of existing providers, and ensured that existing care homes were given priority consideration and an opportunity to submit a redevelopment proposal, rather than having to compete in an open competitive tender. Specifically, the policy required health authorities to issue a request for proposal to at risk residential care service providers, in order to allow them to upgrade an existing care home or convert to assisted living (AL) units, where future need would be for different types of residential care or AL units. Along with promoting the stability of operators and investors, the policy also helped ensure that operators were adequately consulted well in advance of any potential changes to their care homes, potentially lowering costs for the health authorities over the long-term.

Managing Changing Need, Home and Community Care Policy Manual
Policy: *As part of the redesign of home and community care services, health authorities are required to manage the renewal of the Home and Community Care system. This renewal involves upgrading, closing, or converting to assisted living those residential care facilities that are unable to meet the needs of clients with complex care requirements, or are no longer needed in a particular geographic region. Health authorities are required to manage the upgrade, conversion or closure of residential care facilities in the manner set out in this policy.*
Performance Management: *HAs are required to notify a residential care facility service provider of deficiencies identified at any review process and provide a reasonable timeframe for the service provider to correct the deficiencies.*
Residential Care Services Planning and Tendering: *If the future need for residential care beds is less than current supply within a particular geographic area, health authorities may terminate a residential care facility service provider agreement, or close a residential care facility the health authority operates, based on the facility assessed with the highest facility suitability risk.* *If more than one facility is assessed as having high facility suitability risk, the facility with the highest performance risk will be closed. If the future need within a particular geographic area is for different types of residential care beds or assisted living units; health authorities are required to issue a request for proposal to an at-risk facility provider to allow them to upgrade their existing facility, or convert it to assisted living units. If a proposal is not accepted, the service provider agreement with an at-risk residential care facility may be terminated. For all other situations, health authorities may conduct an open proposal call process.*

In 2005, there were negotiations between the BCCPA, care home operators, Ministry of Health, health authorities and lenders on issues related to Managing Changing Need. These negotiations attempted to develop a protocol pursuant to which care providers would have an opportunity to assign for value operating

agreements. This led to the HCC Policy Manual being amended to include the Managing Changing Need policy as outlined below (section 6.D.1).

In 2010, the Managing Changing Need policy was removed from the HCC Policy Manual. The Health Authorities have taken the position that the policy is no longer in effect. This is despite any clear formal written indication that the Ministry of Health has formally revoked the policy or that it is no longer in effect. Overall, until the Ministry of Health indicates otherwise, it is still the BCCPA's position or perception that MCN continues to be in effect.

> "...it will be important to ensure that existing operators are consulted well in advance of any potential changes to their care homes..."

The lack or perceived lack of the Managing Changing Need policy (or comparable policies), has increased risk in the continuing care sector, by: (1) increasing uncertainty in regards to long-term funding, as care homes, which are costly to build, cannot be easily converted to another function or use; (2) increasing uncertainty in long-term employment for continuing care staff; and (3) increasing uncertainty for lenders, as owners rely on long-term funding in relation to debt repayment.

When contracts for funded beds are seemingly arbitrarily terminated, financial institutions might become less willing to provide and renew mortgages to anyone in the sector. As such, financial institutions need assurances of stable revenue from funded beds – something Managing Changing Need helps ensure. The lack of access to affordable mortgages may result in fewer operators being able to refresh, renovate or rebuild and is contrary to the best interests of the BC seniors who require residential care.

Funding agreements with health authorities invariably have a termination provision. In other sectors, such as the transportation sector, they have been able to negotiate deals or contracts with the provincial government that do not have a 365-day termination clause. This has helped secure the necessary funding for large scale capital infrastructure investments such as the Port Mann and Golden Ears Bridges, etc.

Relating to the issue of Managing Changing Need, the next section on capital investment further discusses the need to ensure the appropriate replacement of old care beds, as well as the development of new stock. The following principles, for example, which could assist with this and be developed by an industry, government and Health Authority committee or working group include:

- That all future contracts for new builds in residential care cover a minimum 60-year period (i.e. also consistent with the Alberta approach introduced in 2015);
- If a care home is identified as being in need of renewal, the operator would be given a specified time to draft a comprehensive redevelopment plan that would be given full consideration by the Health Authority it is located in;
- That a care operator has the right to move existing beds, within a specified geographic region - if they are able to demonstrate a bona fide business plan to develop a more modern, resident-centred building [at no additional cost to Health Authority] which can produce better health outcomes; and
- Formal recognition by the MOH that care providers retain the ability to "sell beds" to another operator within the same geographical region – subject to approval by the Health Authority.

OPTION 8 FOR CONSIDERATION:

The BC government clarify or re-affirm its position regarding Managing Changing Need and at minimum reintroduce the policy, or similar policy on an interim basis as part of BC's Home and Community Care (HCC) Policy Manual; and that in the long term the Managing Changing Need Policy or an updated policy be incorporated as part of the existing Community Care and Assisted Living Act and/or accompanying residential care regulations.

Capital investment in continuing care

Partly related to the issue of Managing Changing Need (MCN), is the issue of capital investment in the continuing care sector, particularly for residential care. While non-government care home operators have invested large amounts of capital into their operations, including their physical infrastructure, this is becoming increasingly difficult in the current fiscal environment, as funding lifts currently do not account appropriately for these costs. In particular, BC Care Provider Association (BCCPA) members have historically not been adequately compensated for the costs of the building, maintaining, upgrading and eventually replacing residential care homes, whereas health authority operated care homes are funded fully for these property and infrastructure costs.

The burden of these disincentives is increasing over time as operating revenues (due in part to insufficient funding lifts) have diminished and real costs continue to escalate. This also runs contrary to the government's direction of including private sector involvement in public infrastructure development such as the use of public-private partnerships (P3s).

Compounding these inequities are unfunded wage and non-wage inflation costs, both of which have gradually eroded operating efficiencies used to offset capital costs. The result has led to reduction in the attractiveness of investment within the residential care sector. It has also increased the difficulty some operators are having in maintaining the financial viability of their businesses.

Currently, areas with comparatively high land and building costs such as Vancouver Coastal Health and Fraser Health regions have had the most difficulty in attracting private sector investment to residential care. As a result, highly capitalized, multi-site operators are largely becoming the only organizations to leverage sufficient funds to develop new care homes. Low interest rates have been one of the few positive aspects of the investment environment within the residential care sector.

> "…highly capitalized, multi-site operators are largely becoming the only organizations to leverage sufficient funds to develop new care homes."

Over time, the growing gap between the actual capital cost of maintaining, upgrading or replacing a care home and its ability to recoup efficiencies in staffing, administration or other operating savings to devote to capital has seriously diminished. In particular, the erosion of their ability to cover direct care costs for seniors is one of the most critical aspects of the lack of capital funding for non-government care operators. This is especially troubling since government operated care homes continue to have their entire property costs fully covered while others, including private operators, do not.

In order to fund capital costs, non-government care operators have had to streamline their operations and find efficiencies where possible while still meeting the needs of their residents, as well as complying in some cases to excessive legislative or regulatory requirements. Examples of burdensome legislation include Health Authority requirements around direct care hours (DCH) or staffing ratios, but also the move toward developing care homes with predominately single rooms. This latter change, as advocated by BC's Seniors Advocate, decreases operating revenue per square foot and economic viability.

> "…funding models developed should adequately reflect any capital replacement costs."

Overall, funding models developed should adequately reflect any capital replacement costs. As many care homes age and become physically or functionally obsolete they will need to be replaced. By partnering with the private sector, government would be demonstrating or re-affirming its commitment to reducing health costs and promoting development of an appropriate health infrastructure.

In summary, property related funding inequities reduce private sector investment and increase the aggregate cost of providing residential care infrastructure province-wide. In addition, the costs of renovating or upgrading care homes are significant and for the most part are not economically feasible for many operators under the current capital compensation arrangement.

Along with funding models that better reflect capital investments, the BCCPA also suggests considering exempting care home operators from paying property taxes, which is currently done in other provinces such as Alberta. This change, for example, would go a significant way in allowing non-government operators to recoup capital operating expenses, as well as encouraging further private investment in continuing care sector in order to improve access to new residential care beds and for senior's care.

> "…BCCPA also suggests considering exempting care home operators from paying property taxes, which is currently done in other provinces such as Alberta."

Another potential option is that taken by Ontario, which in October 2014 announced a renewed capital redevelopment plan for long term care (LTC) homes. This has been well-received by LTC home operators who want to bring their homes up to current standards. As outlined by the Ontario Long-Term Care Association, some 52% of Ontario's older LTC Homes – many of them in small communities or rural locations – currently do not meet the most recent (2009) design standards. For example, older homes have three or four-bed wards and cramped living spaces, which do not meet the needs of residents living with dementia and Alzheimer's.[34] Like Ontario, BC faces similar challenges in the redevelopment of its long-term care infrastructure.

The BCCPA is looking at undertaking a more extensive project to look further at the capital investments being made, and that are required to be made in the continuing care sector. In particular, this project will attempt to formalize a position on the value of capital that care providers are investing and/or contributing into their organizations and a mechanism to formalize this funding in an equitable manner. Likewise, it will also review various funding models of the health authorities to determine, if and how capital costs are currently captured.

[34] BUILDING resident-centered long-term care, now and for THE FUTURE. Ontario Long Term Care Association. January 2015. Ontario Long Term Care Association Pre-Budget Submission to the Ontario Government 2015/2016

OPTION 9 FOR CONSIDERATION:
To increase private sector investment and development of residential care capacity across the province, there should be fair and equitable return on the cost of capital.

OPTION 10 FOR CONSIDERATION:
That an industry, government and Health Authority committee or working group be established to study options around creating equitability and sustainability with regards to funding models and private sector investment in continuing care.

OPTION 11 FOR CONSIDERATION:
That the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector, thus allowing residential care homes to have the same tax free status as other health care facilities.

ACTIVITY BASED FUNDING FOR HOME AND COMMUNITY CARE

Recently we have seen examples where jurisdictions are attempting to change the way they fund the provision of home and community care services. Alberta Health Services, for example, is changing the way it allocates money to long-term care operators around the province where funds are distributed based on a new formula that calculates the needs of each resident and provides a standard funding amount to the care provider.[35] Studies, however, have shown serious concerns with this model.[36]

In Alberta, the former LTC funding system was similar to that of global budgeting for hospital care. The strengths of this system are its budgetary predictability and the ability to control costs, but as noted in the literature, it fails to create any financial incentives for providers to increase volume or to transition residents to less intense care when appropriate.[37]

To try and overcome the limitations of global budgeting, Alberta and Ontario recently announced plans to implement activity-based funding (ABF) for long term care in their respective provinces. In Australia and the United States, ABF has also been implemented as a basis for remunerating long-term care or nursing homes, as well as skilled nursing facilities and inpatient rehabilitation.

As outlined in a document from Alberta Health Services (AHS), ABF (or what AHS refers as Patient/Care Based-Funding [PCBF]) is a method used by funders to pay for desired health services. It is an output based allocation method that classifies residents/patients by clinical acuity and resource use, thus attempting to enable consistent and appropriate funding. PCBF provides funding based on care provided to residents/patients as opposed to funding a specific type of bed. The key objective of PCBF is to align incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels. There are two key aspects of PCBF: 1) Grouping residents/patients of similar clinical acuity and

[35] Long-term-care centres brace for cuts under new funding model By Tamara Gignac and Bryan Weismiller, Calgary Herald March 5, 2013. Accessed at: http://www.calgaryherald.com/health/Long+term+care+centres+brace+cuts+under+funding+model/8054364/story.html

[36] The Alberta Health Services Patient/Care– Based Funding Model for Long Term Care: A Review and Analysis. UBC Centre of Health Services and Policy Research. Jason Sutherland, Nadya Repin and Trafford Crump. September 2012. Accessed at: http://www.albertahealthservices.ca/Publications/ahs-pub-ltc-pcbf.pdf

[37] Long Term Care Funding. UBC Centre for Health Services and Policy Research (CHSPR) accessed at: http://healthcarefunding.ca/activity-based-funding/long-term-care/

resource consumption and 2) Quantifying resource use of these groups.[38] As noted by AHS, the key objectives of the PCBF model include the following:

- Achieve equity in funding allocation by focusing on the equitable access and quality of services for residents with similar needs;
- Support consistency in access to care, standards of care, and the amounts paid for care for residents with similar care needs;
- Provide transparent, predictable funding consistent with the quantity, complexity and quality of the services needed by residents;
- Enhance funding predictability for residents, operators, decision-makers & other stakeholders; and
- Provide incentives for improving efficiency and quality in LTC service delivery.[39]

As the use of PCBF or resident focused funding for long-term care is relatively new in Alberta it is not clear what impact it has had on the provision of care for the elderly. To date, the results outlined in the literature seem to be mixed. For example, according to one analysis, ABF in the United States seems to have adversely effected cost-efficiency in long-term care and the evidence regarding its impact on the quality of care are mixed (Grabowski 2001; Zinn et al 2008). The reduction in cost-efficiency is related to an increase in administrative nursing costs (of approximately 4%).[40]

In some for-profit long-term care homes, a reduction in nurse staffing levels has also been observed (Starkey et al 2005); this is a concern given the finding of a positive relationship between staffing levels and quality of care (Castle et al 2007; Briesacher et al 2009). For example, ABF has been associated with a reduction in rehabilitative services, and the observed association was stronger in private care homes. Despite this, there is some evidence to suggest that more intense competition between care homes is associated with higher scores on quality measures (Liu et al 2003; Schlenker et al 2005; CIHI 2007).[41]

Recently some concerns were expressed about Alberta's activity based funding approach in long-term care, including that one-third of the province's nursing homes were unintentionally inflating their assessments of resident needs and receiving extra funding according to audits by the province's health authority. In particular, according to the audit of the 81 that were reviewed (170 in total), only one care home was found

[38] Patient/Care-Based Funding Long Term Care: User Summary. May 2013. Alberta Health Services. Accessed at: http://www.albertahealthservices.ca/hp/if-hp-in-ltc-user-summary.pdf
[39] Ibid.
[40] Long Term Care Funding. UBC Centre for Health Services and Policy Research (CHSPR) accessed at: http://healthcarefunding.ca/activity-based-funding/long-term-care/
[41] Ibid.

to be "under-coding" the care residents required, while 28 others were "over-coding" resident needs. Of the nursing homes found to have problems, 17 were operated by AHS, six were non-profits, and six were privately owned.[42]

> "…one-third of Alberta's nursing homes were unintentionally inflating their assessments of resident needs and receiving extra funding according to audits by the province's health authority."

While the use of activity based funding for home and community care fits well with BC's emphasis on innovative funding,[43] it may be prudent at this point to evaluate the results of Alberta's experience with PCBF in continuing care before proceeding in that direction. A summary of the pros and cons with respect to this funding model are outlined in the table below.

Pros	Cons
• Provides greater financial incentives for providers to increase volume or transition residents/patients to less intense care when appropriate. • Use of activity based funding for long-term care fits well with BC's emphasis and innovations in resident/patient focused funding, particularly for hospital care.	• Use of global funding provides greater budgetary predictability and potential ability to control costs. • Not clear what impact it has had on the provision of care for the elderly. To date as outlined in the literature the results seem to be mixed. • Could result in deliberate or unintentional under coding or over coding of residents/patients. • Has resulted in reductions nurse staffing levels in some cases. • Could create excessive administrative burdens and red-tape.

OUTCOME-BASED FUNDING

> "… the BCCPA believes that government should undertake a comprehensive review of the lessons learned in the use of patient/resident and outcome based funding… to date, for example, these initiatives have been less than positive…"

In the continuing care sector, outcome based or performance based funding is not widely used. Outcome or performance based funding is incentive based funding for service providers where they must reach pre-determined outcomes on a quality or performance scale in order to receive extra or bonus compensation.[44] The idea behind outcome based funding is to reward providers through performance and quality benchmarks that correlate to higher quality of care within the sector. The model measures quality of care based off a points system where

[42] One-third of nursing homes "over-coding" to get bigger share of $930M pie. Matt McClure, Calgary Herald. December 12, 2014. Accessed at: http://calgaryherald.com/news/politics/one-third-of-nursing-homes-over-coding-to-get-bigger-share-of-930m-pie
[43] BC launches patient-focused funding province wide. April 12, 2010. Accessed at: http://www2.news.gov.bc.ca/news_releases_2009-2013/2010HSERV0020-000403.htm
[44] University of British Columbia. "Glossary", accessed at: http://healthcarefunding.sites.olt.ubc.ca/glossary/

care providers can gain points by achieving various indicators including access to care, efficiency, and client satisfaction.[45]

The Vancouver Coastal Health Authority has experimented with an outcome or performance based funding model in homecare, through implementing the Accountability, Responsiveness, and Quality for Clients Model of Home Support (ARQ Model). The ARQ model integrates cluster care in high-density neighborhoods/buildings with performance based funding off measurable outcomes.[46] Essentially, cluster care seeks to provide consistent care using a single home support team in neighborhood/ building areas where client needs are fluctuating, and by shifting from traditional hour-based funding to block funding.[47]

By focusing on performance management as opposed to just hourly wages, VCH hopes to improve client satisfaction with their homecare by ensuring high quality services through accurate reporting on performance, and creating joint performance requirements with VCH and contracted homecare providers.[48] Evaluation of the ARQ model found higher efficiency in care due to clients being clustered in close proximity to each other, appropriate matching between the client and caregiver abilities, and higher levels of client satisfaction.[49]

In 2011/12, Alberta Health Services also experimented with a Pay for Performance (P4P) model within long-term care, making a 0.2% funding lift available to government owned and operated providers who exceeded five specific quality metrics. Within this model, providers expressed that there could be links between funding and quality and that the funding lift percentage combined with the quality metrics could enable higher quality of care. However, some providers expressed that the lag between payment and the activity occurring was too long, as well as, some of the quality metrics being unreasonably difficult to reach.[50]

Other jurisdictions including Nova Scotia are also looking very closely at outcome or performance based funding. In July 2015, for example, Nova Scotia released its *Continuing Care – A Path to 2017* document outlining a path forward for long-term care, home care, and related services.[51] As outlined in the report

[45] Yan, C., Riechers, J., & Chuck, A. (2009) "Financial Incentives to Physician Practices: A literature review of evaluations of physician remuneration models". Institute of Health Economics, Alberta Canada. Accessed at: http://www.ihe.ca/publications/financial-incentives-to-physician-practices-a-literature-review-of-evaluations-of-physician-remuneration-models

[46] KPMG (2008). "Central LHIN Health Service Needs Assessment and Gap Analysis. Appendix Q: Jurisdictional review". Slide 16.

[47] Sutherland, J., Repin, N., Crum, R. (2008). "Reviewing the Potential Roles of Financial Incentives for Funding Healthcare in Canada". *Canadian Foundation for Healthcare Improvement.* Accessed at: http://www.cfhi-fcass.ca/Libraries/Reports/Reviewing-Financial-Incentives-Sutherland-E.sflb.ashx

[48] Vancouver Coastal Health. "A Model for Improved Home Support in Vancouver". Accessed at: http://www.crncc.ca/knowledge/related_reports/pdf/AModelforImprovedHomeSupportinVancouver.pdf

[49] University of British Columbia. "Evidence and Perspective on Funding Healthcare in Canada". Accessed at: http://healthcarefunding.ca/home-care/

[50] Sutherland J., Repin, N., Crump, R. (2013) "The Alberta Health Services Patient/Care– Based Funding Model for Long Term Care: A Review and Analysis". University of British Columbia. Accessed at: http://www.albertahealthservices.ca/Publications/ahs-pub-ltc-pcbf.pdf

[51] Nova Scotia Health and Wellness. Nova Scotia Government Seeks Input on Continuing Care Plan. July 30, 2015. Accessed at http://novascotia.ca/News/Release/?id=20150730002

implementing performance-based contracts for long-term and home-care providers, with key performance indicators and targets to measure and monitor access, efficiency, and outcomes, will help to create a more accountable, sustainable system.[52]

Overall, the BCCPA believes that government should undertake a comprehensive review of the lessons learned in the use of patient/resident and outcome based funding for provision of home and community care, particularly reviewing any outcomes and/or results from Alberta and Ontario's experimentation with the initiatives. To date, for example, these initiatives have been less then positive and, in some cases, have had unintended consequences such as inappropriate coding, as well as resulting in differing levels of care across a particular jurisdiction.

The BCCPA also believes if such models are advanced that the nine Canadian Institute of Health Information (CIHI) long-term care indicators may not be the best indicators and could be improved upon. While the BCCPA and its members support improving the transparency of information, including reporting on various long term care (LTC) indicators, the CIHI indicators only provide a snapshot on areas of care for seniors within LTC and do not represent the whole picture or entire level of care provided.

OPTION 12 FOR CONSIDERATION:
That the BC Ministry of Health undertake a comprehensive review of the outcomes and lessons learned in the use of activity and outcome based funding for provision of home and community care, particularly reviewing any results from Alberta and Ontario's experimentation with these initiatives.

SOCIAL FINANCE

Social Finance is another innovative funding approach that could be considered further to increase the existing stock of residential care beds as well as mobilize capital. Social Finance could encourage private and non-profit investors to meet pre-determined objectives or goals as outlined by government. In particular, it could create opportunities for investors to finance projects that benefit society and allow for community organizations to access new sources of funds.[53]

Social finance is an approach to mobilizing private capital that delivers a social dividend and an economic return, while achieving specific social goals. It creates opportunities for investors to finance projects that benefit society and for community organizations to access new sources of funds.[54] The previous federal Conservative government released a report in May 2013 entitled *Harnessing the Power of Social Finance*, which highlights the benefits of social finance and social innovation in creating new financial tools and partnerships to broaden the impact of existing programs or to support new initiatives.

> "With respect to Social Finance, there may be a number of different ways the concept could be applied to assist seniors, particularly leveraging non-profit and private sector organizations to meet program or income needs with tangible goals and deliverables."

[52] Continuing Care – A Path to 2017. Nova Scotia Government. Accessed at: http://novascotia.ca/dhw/continuingcarerefresh/DHW-ContinuingCare-en.pdf

[53] Harper Government reaffirms commitment to working with communities and private sector to tackle Canada's social challenges. May 6, 2013. Accessed at: http://news.gc.ca/web/articleeng.do;jsessionid=ac1b105330d7b6cd1a96040a452f9fb4fb98868e8880.e38RbhaLb3qNe34Lbh50?mthd=tp&crtr.page=1&nid=738929&crtr.tp1D=1

[54] Ibid.

With respect to Social Finance, there may be a number of different ways the concept could be applied to assist seniors, particularly leveraging non-profit and private sector organizations to meet program or income needs with tangible goals and deliverables.

With any new funding approach, however, there will ultimately be pros and cons. The main advantage of using social finance models is that it could allow cash strapped governments to delay expenditures, particularly during tough economic times. Another advantage is that it may allow non-profit and private sector organizations to provide some greater level of innovation and/or accountability. Some of the negatives of the Social Finance approach are that it is unclear what effect this approach has on costs in the long-term. In particular, social finance is more meant to delay costs, and may end up actually increasing expenditures over the long-term. Along with uncertainty around the costs involved, there would be additional administrative costs to deal with the developing and enforcement of contracts with non-profit and private sector organizations.

British Columbia, as part of its commitment to social innovation, introduced Community Contribution Companies (C3) in July 2013. A C3 status signals that a company has a legal obligation to conduct business for social purposes and not purely for private gain.[55] Like a traditional corporation, they can pay dividends to shareholders, but they must invest the majority of their profits in achieving a social purpose. This model allows social enterprises to receive equity investment and gives investors the assurance that the investment will have a positive social impact.

Social Impact Bonds

With the recent announcement on C3s it will be important to see how these develop over time. There are, however, areas within Social Finance that could be looked at further today. One particular area that may merit further consideration is that of social impact bonds for seniors' supportive housing. Social Impact Bonds (SIBs) are essentially a contract with the public sector in which a commitment is made to pay for improved social outcomes that result in public sector savings.

The first SIB was launched in the UK in September 2010, where SIBs are designed to transfer the risk of social programs from the public sector to the private sector. Investors fund interventions in a range of areas, from prisoner rehabilitation to sheltering the homeless. If the programs succeed, the state pays the investors and saves money as well. As outlined on the UK government website, SIBs improve the social outcomes of publicly funded services by making funding conditional on achieving results in which investors pay for the project at the start, and then receive payments based on the results achieved by the project. Rather than focusing on inputs (e.g. number of doctors) or outputs (e.g. number of operations), SIBs are based on achieving social 'outcomes' (e.g. improved health). The outcomes are predefined and measurable.[56] Pros and cons of SIBs are outlined in table below:

[55] Registration opens for innovative new business model. Monday, July 29, 2013. Accessed at: http://www.newsroom.gov.bc.ca/2013/07/registration-opens-for-innovative-new-business-model.html

[56] Government of UK. Social Impact Bonds. Accessed at: https://www.gov.uk/social-impact-bonds

Pros	Cons
• Public sector only has to pay for effective services as third party investor bears risk of services being potentially ineffective. • Investors and servicers have an incentive to be as effective as possible as the larger impact they have on the outcome, the larger the repayment they will receive. • Can include ongoing evaluation of program impacts into program operations. • Way to attract new forms of capital to the social, educational and healthcare sectors. • Independent evaluation may result in greater transparency.	• Donors may only seek to fund those areas which can be observed and measured, namely the outcomes (not just the outputs). • Increased donor influence, or now investors, will want to make sure their money is being used according to contract, and will want to be more involved in delivery of social services. • Reduces government's responsibilities and accountability for delivering services. • Likely increased administrative expenses with development and enforcement of contracts, etc... • Project can face increased risk if it does not have strong financial management.

OPTION 13 FOR CONSIDERATION:
The BC government explore further the use of Social Finance arrangements including Social Impact Bonds to fund new potential investments within the continuing care sector.

Charitable contributions to Home and Community Care sector

Related to the issue of new social financing arrangements, is improving how existing charitable and/or estate contributions can be mobilized to assist the continuing care sector. Currently, for example, there is no designated charity or entity to which people can donate monies or bequeath their estates to, in order to assist the continuing care sector.

An example of such a charitable entity is Streetohome Foundation, a Vancouver based foundation that provides funding and support to provide housing for the homeless. As part of this organization, people can donate money or bequeath their estate to provide housing for the homeless. Likewise, a similar organization could also be established in which people could donate funds or bequeath their estates to assist seniors living in the home and community care sector. As part of such an organization or entity, governments could also potentially match funding donated to go towards specific purposes such as new technologies to alleviate senior's isolation, or improve resident safety (i.e. new ceiling lifts for residents).

EXPLORING OPTIONS FOR FINANCING CONTINUING CARE

The Canadian Life and Health Association (CLHIA) notes that over the next 35 years the cost of providing long-term care in Canada will be $1.2-trillion, with only half of that covered by current government programs.[57] A 2015 report from the Conference Board of Canada estimates that by 2026, over 2.4 million Canadians age 65 years and older will require paid and unpaid continuing care supports—a 71 per cent increase over 2011. By 2046, this number will reach nearly 3.3 million people.[58]

[57] Improving the Accessibility, Quality and Sustainability of Long-Term Care in Canada. June 2012. Canadian Life and Health Association. Accessed at http://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/resources/Content_PDFs/$file/LTC_Policy_Paper.pdf

[58] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015.

More remarkably, the Conference Board of Canada report notes that total spending on continuing care supports for seniors is projected to increase from $28.3 billion in 2011 to $177.3 billion in 2046. With nearly two-thirds of this spending likely to continue to be provided by governments, spending growth will significantly exceed the pace of revenue growth in most provinces. [59]

DID YOU KNOW: …the Conference Board of Canada report notes that total spending on continuing care supports for seniors is projected to increase from $28.3 billion in 2011 to $177.3 billion in 2046.

A June 2012 study from the Institute of Research and Public Policy (IRPP) also highlights that the current financing of home and community care (HCC) across Canada is a patchwork and that access to HCC and its cost to individuals vary depending on the region where they live.[60]

As a result of future funding challenges it will be important for governments working with stakeholders to explore new approaches to funding continuing care. This paper, in particular discusses several areas including long term or continuing care insurance and co-payments. Likewise, it also touches on use of vouchers.

It should be noted that while a BCCPA report released last year, entitled *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC* does advocate for a major shift of resources from acute to continuing care to meet some of the existing fiscal challenges facing care providers - such as increasing levels of acuity for new residents entering long term care - the BCCPA does not specifically recommend any of the options outlined below.

LONG-TERM CARE INSURANCE

One approach to meet future financing needs for continuing care is long-term care insurance, which is currently very limited in Canada. Long-term care (LTC) insurance is a relatively new product (since about the early 1980's), with policies only beginning to mature in measurable numbers. Long-term care insurance provides policy holders with coverage for a set period of time (e.g. 150 weeks) to cover home and community care expenses (including residential care, as well as home care and support). Individual policy features, however, can vary significantly.

"A report from the IRPP notes that relying on private savings is not an efficient way for individuals to provide for their potential future care needs, as they are likely to save too much or too little."

A report from the IRPP notes that relying on private savings is not an efficient way for individuals to provide for their potential future care needs, as they are likely to save too much or too little. In particular, the IRRP report recommends governments adopt a universal public insurance plan that provides full coverage based on a standard evaluation of care needs in order to reduce uncertainty for ageing Canadians and be more equitable. [61]

An earlier Quebec government had proposed creating Autonomy Insurance, which would provide home care services through a protected funding mechanism that optimizes resource allocation. The insurance would be available to seniors with functional or cognitive loss of autonomy, adults with physical disabilities, and adults with intellectual disabilities. The insurance would be funded through the annual government amount

[59] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015.
[60] Financing Long-Term Care in Canada. Institute for Research and Public Policy. IRPP Study No. 33, June 2012. Michel Grignon and Nicole F. Bernier. Accessed at http://irpp.org/wp-content/uploads/assets/research/faces-of-aging/financing-long-term-care/IRPP-Study-no33.pdf
[61] Ibid.

available for long-term services, user fees, and fiscal expenditures equal to Quebec's Tax Credit for Home-Support Services for Seniors.

As outlined in an earlier Quebec report, two long-term care insurance models have been developed within the health systems of various countries. Some have opted to extend long-term care and service coverage within a taxation-funded public system. In this model, private care providers are less involved, while certain types of services do require contributions from individual users. This type of system applies in Canada as a whole, the United Kingdom, Sweden and Denmark, with some organizational and management differences. Other countries such as France, Germany, Japan, and Spain rely on private insurance plans for LTC, partially funded by mandatory employment premiums and the tax system (see Appendix E).[62]

Quebec Autonomy Insurance

Quebec was previously pursuing the concept of LTC insurance (or what it calls autonomy insurance), having released a White Paper on the topic in May of 2013. As outlined in the paper, introducing autonomy insurance presupposes three conditions:

- Moving resources and well-planned, organized and coordinated services to locations where persons with well-defined needs reside;
- Transitioning from a system of care and services designed and structured for a young population to a system that gives priority to the needs of an ageing population; and
- Making a protected funding mechanism available to cover services that are adapted to needs and to optimise resource allocation.[63]

In December 2013, the Quebec government tabled Bill 67 (Autonomy Insurance legislation). The insurance fund would have covered services needed for daily life — including domestic help, bathing, cooking and nutritional evaluations, as well as special equipment, nursing care, psychological and rehabilitation services. Eligibility was to be determined by a community health clinic case manager, who would then develop a homecare plan with the family that would have to be approved by the elderly person receiving the care. Bill 67 called for a budget of $500 million to support and implement the insurance fund over five years. Under the insurance plan, those in nursing homes would have also been eligible for coverage for some of the care they

[62] Quebec Government. Report from the Committee on Health and Social Services. Autonomy for All: White Paper on the Creation of Autonomy Insurance. 2013. Accessed at: http://www.assnat.qc.ca/en/travaux-parlementaires/commissions/csss/mandats/Mandat-24161/index.html
[63] Ibid.

receive there. Rates would been set by the government based on a person's income, old age, and disability pensions.

It is not clear as of yet what form Quebec's Autonomy Insurance will ultimately take and whether other jurisdictions in Canada will follow suit. Further study of this issue should be carried out before a decision is made on provinces and territories (P/Ts) collaborating in the area on LTC insurance, including whether to offer incentives to purchase LTC insurance. Quebec has also put on hold issue of Autonomy Insurance following the change in provincial government.

"Under Quebec's Autonomy Insurance Plan the insurance plan, those in nursing homes would have also been eligible for coverage for some of the care they receive there. Rates would been set by the government based on a person's income, old age, and disability pensions."

LTC / Autonomy Insurance in British Columbia

Advancing the issue of LTC insurance in any meaningful way will likely require some federal involvement. Provinces have made previous requests, for example, to the federal government to make premiums for long-term care insurance deductible for income tax purposes, as an incentive for people to purchase the insurance. Deductions from income would apply equally across Canada (except Quebec). Tax incentives are typically designed in two ways: either as a deduction from taxable income or as a tax credit.

"Although BC is unable to implement tax deductions, it could introduce a tax credit for long-term care insurance premiums."

Although BC is unable to implement tax deductions, it could introduce a tax credit for long-term care insurance premiums. The province could set a tax credit rate of whatever amount it choses, and could target the credit based on income. However, the province would bear the full cost of the credit. In addition, the province would pay for credits to taxpayers who then move to other provinces, resulting in a cost to BC and a savings to other provinces.

Whatever approach is taken in BC, the idea of LTC or Autonomy Insurance is one that merits further study and consideration, particularly with an ageing population and as long-term care expenses continue to increase. For example, a 2013 OECD study concludes that while public health costs dropped by 1.4% between 2008 and 2010 among 17 selected member countries, long-term care expenditures increased by 3.4%. Although not exhaustive, a list of some of the potential pros and cons and implementing a LTC insurance system in British Columbia are outlined below:

Pros	Cons
• There is a potential need for such insurance as long-term care costs continue to escalate particularly with an ageing population. • Has been implemented with relative success in other jurisdictions (i.e. Germany and Japan - see Appendix E further information) • Current financing of LTC across the country is a patchwork and that access to LTC and its cost to individuals vary depending on the region where they live and whether they are	• Long-term care (LTC) insurance is a relatively new product (since about the early 1980's), with policies only beginning to mature in measurable numbers. • To advance the issue of LTC insurance in any meaningful way it will likely require some federal involvement. • Implementation of mandatory LTC insurance system could increase tax burden of citizens unless accompanied by other tax reduction.

still at home or in a residential care home. LTC insurance could partially ameliorate this issue. • Private savings may not be an efficient way for individuals to provide for their potential future care needs, as they are likely to save too much or too little.	

OPTION 14 FOR CONSIDERATION:

That provincial and/or federal governments explore reviewing further the concept of long-term care or autonomy insurance to address issues of an ageing population and increasing home and community care expenditures.

REVIEWING EXISTING CO-PAYMENTS FOR RESIDENTIAL CARE

Under Residential Care arrangements, seniors pay up to 80% of their after-tax income on a monthly basis to cover the cost of housing and hospitality services including meals, routine laundry and housekeeping, subject to a minimum and maximum monthly rate. As of 2016, the maximum monthly rate for a client receiving family care home or residential care services is $3,198.50 per month. The maximum client rate is also adjusted annually based on changes to Consumer Price Index.[64] Similarly, publically subsidized Assisted Living residents pay a maximum of 70 per cent of their after-tax income (unless that figure exceeds the actual cost of the service).[65]

> "…although the maximum monthly rate that British Columbia's long term care homes can charge residents is over $3,000, the average resident pays considerably less."

As noted in a recent report from the Conference Board of Canada, although the maximum monthly rate that British Columbia's long term care homes can charge residents is over $3,000, the average resident pays considerably less. In BC, less than ten per cent of seniors in residential care pay the maximum amount. In particular, the average resident in 2012 only paid around $1,200, which represented 23 per cent of the actual cost that year.

Like BC, most of the overall long term care funding in Canada comes from public sources. As the following table below summarizes, in no province in 2012 did the average resident pay more than a quarter of average LTC operational costs (see Table 4).[66]

In summary, the BCCPA believes co-payments for home and community care should be explored further including potentially to ensure that they better reflect the actual costs of delivering care and a resident's/client's ability to pay.

[64] In each province, including BC, minimum private care home-based costs are closely integrated with the federal public income-support system for seniors. For single individuals and couples, minimum care home fees are set according to Old Age Security (OAS) and Guaranteed Income Supplement (GIS) maximum monthly payments. Each individual living in a residential care home is also entitled to a minimum monthly allowance for personal expenses. Those with incomes greater than basic OAS/GIS levels face a claw back of their subsidy (i.e. must pay higher long-term care fees, up to a specified maximum). In most jurisdictions, the claw back rate is 100 percent, meaning that patients must pay an additional dollar in fees for each dollar of income above the basic OAS/GIS threshold.

[65] Ombudsperson Report. The Best of Care: Getting It Right for Seniors in British Columbia (Part 1) - Public Report No. 47. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf

[66] Understanding Health and Social Services for Seniors in Canada. Conference Board of Canada. David Verbeeten, Philip Astles, and Gabriela Prada. April 2015.

Table 4: LTC Cost Structure and Percentage Covered by Resident, Averages, by Province, 2012					
	Annual cost to resident ($)	Monthly cost to resident ($)	Actual total annual cost per resident ($)	Actual total monthly cost per resident ($)	Cost covered by resident %
B.C.	15,337	1,278	66,531	5,544	23
Alta.	11,552	963	60,791	5,066	19
Sask.	13,965	1,164	97,543	8,129	14
Man.	13,138	1,095	69,634	5,803	19
Ont.	16,002	1,334	66,022	5,502	24
Que.	N/A	N/A	N/A	N/A	N/A
N.B.	11,598	967	76,713	6,393	15
P.E.I.	14,497	1,208	72,590	6,049	20
N.S.	15,766	1,314	72,703	6,059	22
N.L.	11,635	970	70,832	5,903	16
TE[1]	8,254	688	116,822	9,735	7

1 TE = Territories. Information was not available for individual territories. Sources: The Conference Board of Canada; Statistics Canada.

"One such alternative could be to get rid of the co-payment cap and, thus, require people to pay closer to the full costs of care."

One such alternative could be to get rid of the co-payment cap and, thus, require people to pay closer to the full costs of care. For example, one potential proposal is that those with incomes over the projected total costs of residential care in BC (i.e. $66,500) could have their income clawed back at a rate of up to 100% until the threshold is met. For incomes below the amount, the thresholds could be lower. As is currently the case, a certain amount could also be left over each month for personal expenses (i.e. similar to the $325 that is left over for very low income seniors). Additionally, differentials for private versus shared rooms could also be considered.

Along with generating additional revenue and better reflecting an individual's ability to pay for residential care, one other advantage of such a proposal is that it could assist with creating more demand for additional private pay beds. As most of the continuing care system costs are currently publically subsidized, including for seniors with higher incomes, there is less demand for private pay beds. If co-payments for publically subsidized beds increased there would likely be a greater market for private pay beds including additional capital stock of beds created as individuals who otherwise would have went to publically subsidized beds would opt to go to private-pay beds instead.

Any changes or review of co-payments should, however, ensure that it does not have any unintended consequences which negatively impact the financial situation of seniors. In particular, seniors with lower incomes should be protected.

As outlined earlier, the provincial government does not pay the full cost of residential care and generally requires residents to pay most of

Table 5: Provincial Co-Payment Rates	
Province	Co-payment per day
NB	$107.00
NS	$102.50
BC	$100.57
NL	$92.05
MB	$79.20
PEI	$77.60
SK	$64.57
ON	$48.15
AB	$48.15
QC	$36.10

Source: BUILDING resident-centered long-term care, now and for THE FUTURE. OLTCA. January 2015. Ontario Long Term Care Association Pre-Budget Submission to the Ontario Government 2015/2016

their 'room and board' expenses. The government sets the amount residents must pay through co-payments. Similar to other provinces, the BC government has been increasing resident co-payments annually largely based on CPI. Actual co-payment rates vary by province, with BC already having among the highest in Canada (see table 5).

> "The UK, for example, recently announced changes to its funding for elderly care, including introducing a cap in April 2016 on total costs an individual can pay for long-term care at £72,000 over their lifetime."

Along with potentially removing the cap for co-payments to residential care, another option could be to look at implementing a total cap for all payments that an individual could pay. The UK, for example, recently announced changes to its funding for elderly care, including introducing a cap in April 2016 on total costs an individual can pay for long-term care at £72,000 over their lifetime.

OPTION 15 FOR CONSIDERATION:

BC government explore existing co-payments for continuing care to ensure that they better reflect actual costs of delivering care and a resident's/client's ability to pay, while ensuring seniors with lower incomes are protected.

VOUCHERS

In Canada – in contrast to countries such as France, Germany, Sweden, Finland, and Denmark – the provision of subsidized long-term care is almost entirely in kind rather than in cash or vouchers. Resident co-payments for both home care and residential-based services are fixed, and the provincial government, not the resident, pays the residual costs of services supplied to subsidized residents (see appendix F).[67]

> "In Canada – in contrast to countries such as France, Germany, Sweden, Finland, and Denmark – the provision of subsidized long-term care is almost entirely in kind rather than in cash or vouchers."

As outlined in a 2012 CD Howe report, new funding models such as vouchers are intended to be more reactive to clients' needs by enhancing the ability of people to stay in their homes for as long as possible. In particular, financial and service flows for funding long-term care in France and the Nordic countries are intended to give clients a greater say over their path of care.[68] Instead of acting as the agent that pays for long-term care on behalf of recipients, government provides needs and risk-adjusted transfers to clients with which they can purchase services from a variety of potential providers. While government in these countries still plays a critical role in regulating providers and ensuring they meet a minimum quality of care, they no longer contract with providers, who now engage clients directly.[69]

The trend in many advanced countries toward the use of vouchers rather than providing services in kind was motivated in part by the belief that more choice for clients and competition among providers would lead to efficiency gains in the system and promote independence, if possible. The available evidence so far is not

[67] Long-Term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012.
[68] Ibid.
[69] Ibid.

clear as to whether these efficiency gains have materialized, although providing greater choice generally has seemed to increase the reported satisfaction of clients.

In particular, although many clients who were receiving cash or voucher transfers were not aware of the choices available to them and very few reported switching from one provider to another (OECD 2011), they nevertheless appear to have valued being involved in decisions about their long-term care, especially when also required to pay significant private costs. [70]

Although there are some potential benefits of vouchers, they do have possible drawbacks. One concern is that providers will seek out clients with low-care needs relative to costs (i.e. the cream-skimming problem familiar from private health insurance). Another concern is the increased difficulty of governments to exercise a high level of control over their annual health budgets. Furthermore, under a voucher system, providers could increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. A final potential weakness of a voucher system is that the size of the voucher, or public subsidy, needs to change over time with a client's needs. [71]

As noted by authors Blomqvist and Busby, establishing a new comprehensive self-directed model such as the use of a voucher system would require the following: an assessment system; means testing; a funding mechanism that is based on need but controls government costs; an oversight system to ensure quality and enforce restrictions on use; and establish who will oversee, coordinate and be accountable for care. [72]

Based on available information, the use of vouchers should be explored further for adoption. Mitigating drawbacks such as cream skimming and increasing prices for services will also need to be looked at further if such a model of funding is adopted.

[70] Ibid
[71] Ibid.
[72] CD Howe Institute. Commentary No. 443. Ake Blomqvist and Colin Busby. Shifting Towards Autonomy: A Continuing Care Model for Canada.

Pros	Cons
• Vouchers are intended to be more reactive to clients' needs by enhancing the ability of people to stay in their homes rather than in residential care homes for as long as possible. • Increases client satisfaction, as well as gives clients a greater choice and say over their path of care. • More choice for clients and competition among providers could lead to efficiency gains in the system and promote independence. • Has been implemented with relative success in other jurisdictions (i.e. Nordic countries, France, Germany, etc. – see Appendix F).	• Not clear as to whether efficiency gains have materialized. • Administrative costs to implement a voucher system, including adjusting the size of the voucher, or public subsidy, to change over time with a client's needs. • Under such system, providers may seek out clients with low-care needs relative to costs (i.e. cream-skimming). • Could decrease governments ability to exercise a high level of control over their annual health budgets. • Providers could increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. • Unclear whether financial institutions will provide funding for capital development within the residential care sector based on projected public expenditures through a voucher system.

OPTION 17 FOR CONSIDERATION:
BC government explore use of vouchers and whether they could be provided to seniors to pay for long-term care and/or assisted living services in lieu of government provision of such services.

CONCLUSION

In order to ensure more appropriate and long term sustainable funding, this report advocates that the BC government, in consultation with operators, develop residential care funding models that accurately factor in increases to operating costs including wages, inflation, overhead as well as other areas such as increasing levels of acuity among residents.

"…this report advocates that the BC government, in consultation with operators, develop residential care funding models that accurately factor in increases to operating costs including wages, inflation, overhead as well as other areas such as increasing levels of acuity among residents."

This report also suggests the BC government move towards a funding model that separates the bodies that fund, allocate funds, and regulate care homes from those that operate care homes. Along with separating the funding and operations of residential care homes, the BC Care Providers Association (BCCPA) encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts are provided for residential care.

With respect to home and community care funding models, the BCPCA advocates that the BC government and health authorities adhere to the core funding principles of timeliness, sustainability, equity and transparency. Furthermore, the BCCPA advocates that the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreements.

Likewise, the report also suggests that the BC government work towards the establishment of predictable, long-term funding models that are outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3 to 5-year period.

> "…as a starting point, the BCCPA encourages the BC government to affirm the Managing Changing Need Policy as part of BC's Home and Community Care Policy Manual, or at minimum ensure that similar provisions exist elsewhere."

In addition to improved funding, it will be important to ensure that operators be appropriately consulted. Therefore, as a starting point, the BCCPA encourages the BC government to affirm the Managing Changing Need Policy as part of BC's Home and Community Care Policy Manual, or at minimum ensure that similar provisions exist elsewhere. This report also suggests that new designated funding be redirected to home and community care, including improving capital investment within residential care.

This report also suggests that new designated funding be redirected to home and community care. As well as providing more predictable funding, the paper suggests that the federal government must also play a role by working with provinces and territories on the development of a new infrastructure fund for home and community care, as well as establishing an age-adjusted Canada Health Transfer. New funding models will also need to be explored including use of activity and outcome based funding, particularly reviewing any outcomes and/or results from Alberta and Ontario's experimentation with the initiative.

This report also identifies the importance of capital investment in continuing care and suggests that an industry, government and Health Authority committee or working group be established to study options around creating equitability and sustainability with regards to funding models and private sector investment in continuing care. Furthermore, in order to increase private sector investment and development of residential care capacity across the province, there should be fair and equitable capital cost coverage. Finally, this paper suggests that the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector.

Alternative ways to fund home and community care also need to be explored, including using Social Finance arrangements; for example, Social Impact Bonds, and long-term care insurance. Finally, the paper also looks at reviewing existing co-payments for home and community care to better reflect actual costs of delivering care, and explore the use of vouchers.

In the process of developing this White Paper, the BC Ministry of Health in April 2016 announced it will be undertaking a review of staffing guidelines in government-funded long-term care homes for seniors after a report from the province's seniors advocate.[73] In particular, BC Heath Minister Terry Lake requested the Ministry undertake a review to examine how health authorities are funding seniors' homes, including looking

[73] Office of the Seniors Advocate. British Columbia Residential Care Facilities: Quick Facts Directory. January 2016. http://www.seniorsadvocatebc.ca/osa-reports/british-columbia-residential-care-facilities-quick-facts-directory/

at the care hours for different types of seniors, such as those facing dementia and other ailments.[74] Further details on this review will be forthcoming but the BCCPA, which generally supports such a review, hopes that some of the options outlined in this report may also assist the review process.

OPTIONS FOR REVIEW / CONSIDERATION

Long-term sustainable funding:

1. The BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well adhering to the core principles of timeliness, sustainability, equity and transparency.

2. The BC Care Providers Association (BCCPA) encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts for home and community care are determined.

3. That the BC government, in order to remove the perception of a conflict of interest, consider moving towards a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

4. That the BC government, in consultation with operators, develop residential care funding models that accurately factor in increases to operating costs including wages, inflation, overhead as well as other areas such as increasing levels of acuity among residents and clients.

5. The BC government work towards establishing predictable long-term funding models by end of fiscal 2018, that are outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3 to 5 year period.

6. That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

New federal Health Accord:

7. That the provincial government as part of any new federal Health Accord advocate that the following elements be included:

    - The establishment of an age-adjusted Canada Health Transfer that reallocates funding to provinces such as British Columbia with higher and growing portions of seniors;
    - New and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new continuing care models for residential care and home support; and
    - Meet commitments outlined in federal liberal platform including a long term agreement on funding; invest $3 billion over the next four years to deliver more and better home care services for all Canadians; develop a pan-Canadian collaboration on health innovation; as well as improve access to necessary prescription medications, particularly for seniors.

[74] Vancouver Sun. BC Health Minister Orders Review of Staffing Guidelines in Long-Term Care Homes for Seniors. April 7, 2016. http://vancouversun.com/news/local-news/b-c-health-minister-orders-review-of-staffing-guidelines-in-long-term-care-homes-for-seniors

Managing Changing Need:

8. The BC government clarify or re-affirm its position regarding Managing Changing Need and at minimum reintroduce the policy, or similar policy on an interim basis as part of BC's Home and Community Care (HCC) Policy Manual; and that in the long term the Managing Changing Need Policy or an updated policy be incorporated as part of the existing Community Care and Assisted Living Act and/or accompanying residential care regulations.

Capital Investment in Continuing Care:

9. To increase private sector investment and development of residential care capacity across the province, there should be fair and equitable capital cost coverage including an immediate increase to the current per resident day amount;

10. That an industry, government and Health Authority committee or working group be established to study options around creating equitability and sustainability with regards to funding models and private sector investment in continuing care.

11. That the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector, thus allowing residential care homes to have the same tax free status as other health care facilities.

Activity / Outcome Based Funding:

12. That the BC Ministry of Health undertake a comprehensive review of the outcomes and lessons learned in the use of activity and outcome based funding for provision of home and community care, particularly reviewing any results from Alberta and Ontario's experimentation with these initiatives.

Social Finance – new partnerships:

13. The BC government explore further the use of Social Finance arrangements including Social Impact Bonds to fund new potential investments within the continuing care sector.

Long-Term Care Insurance:

14. That provincial and/or federal governments explore reviewing further the concept of long-term care or autonomy insurance to address issues of an ageing population and increasing home and community care expenditures.

Review of co-payments for home and community care:

15. BC government explore existing co-payments for continuing care to better reflect actual costs of delivering care, and a resident's/client's ability to pay, while also ensuring seniors with lower incomes are protected.

Vouchers:

16. BC government explore the use of vouchers and whether they could be provided to seniors to pay for long-term care and/or assisted living services in lieu of government provision of such services.

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Appendix A: Key Points from Ministry of Health Papers relating to the Continuing Care Sector

- Existing expenditures will be protected, appropriate reallocations from the acute to the community services sector must become part of go forward health authority planning and going forward a majority of net new funding must be assigned to developing primary and community services.
- Available primary and community care operational and capital funding will be used to improve community-based services in a manner that is reflective of the changing population health care needs and the principles of community based services, integration, quality and value for money.
- Recommendations will be subject to consultation and refinement over winter but it is intended that the final recommendations will be implemented as part of a multi-year primary and community care transformational plan, starting April 2015.
- The Ministry of Health will collaboratively conduct a review of the major primary and community care policy, initiatives and incentives reviewed in this paper late spring of 2015 to ensure they are aligned with the common set of principles set out above and streamlined into a coherent go forward policy framework.
- A single oversight and shared governance model will be developed for primary and community care that includes representation from key players involved in primary and community care. There will be a two-day forum in late spring to discuss the outcome of the review and feedback on the proposed directions set out.
- A range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care; they will have ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services. These practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care.
- Over the next 3 years, implement the Renewed Dementia Action Plan including the four priorities with their concrete actions: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care homes and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care.
- Continue the implementation the End-of-Life Care Action Plan and its key actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.
- Improving geriatric care across the continuum of health service delivery is a key factor in ensuring appropriate care designed to promote the best outcomes and quality of life.
- Related to the above challenges is the way that home and community care services are currently funded, with a co-payment model with user fees charged to clients based on their income for home support, assisted living and residential care services.
- With redesign of services and the transition to new innovative care models focused on interdisciplinary teams, new options for subsidizing clients who may not be able to afford the cost of necessary services need to be explored. This will include exploring how other jurisdictions fund home support, assisted living and residential care services and include a dialogue with health authorities and major stakeholders on how to provide the services.

- For the balance of 2015/16 through 2016/17 it is proposed that there will be three cross sector health sector strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the coming five years to better position it to meet both increasing and changing patterns of demand:
    - Improving the effectiveness of primary, community (including residential care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use such as to significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care.
    - Significantly improving timely access to appropriate surgical treatments and procedures.
    - Establishing a coherent and sustainable approach to delivering rural health services
- B.C. utilization and current funding approaches to residential care services are suboptimal from a number of perspectives:
    - there are opportunities to provide support services to patients both in the community and in assisted living that could reduce the need for residential care;
    - there are opportunities to increase planned admissions to residential care rather than admissions through the ER and in-hospital bed use; there are opportunities to better meet the care (including the increasing number of patients with dementia) and health needs of elderly patients in residential care homes rather than through hospitals, including the development of short term respite beds for community patients with less acute medical conditions and complications;
    - there is increased fiscal capacity to add placements through private capital funding and longer term publicly funded contracting of placements.
- Over the coming three months we will be asking people across the health sector to read, think and dialogue the Cross Sector Policy Discussion Papers. We will be seeking feedback through a formal process with Health Authorities, Patients as Partners, Professional Colleges/Associations, the Doctors of BC, ARNBC, Post-Secondary Academic Institutions and the research community, and Health Service Unions.
- Following consultation with Health Authority Boards and the Minister of Health, we will report out by mid-spring on the feedback, our assessment of consensus, any changes to the policy direction, and the concrete actions we are proposing to move forward on over the coming two years.
- The Ministry of Health will create further space for dialogue with stakeholders and Patients as Partners by hosting a primary and community care public forum in late spring 2015. By attending the forum to share your experiences and by taking advantage of other opportunities for dialogue in your communities you could help shape the pace of change.
- The Ministry of Health in collaboration with Health Authorities, Colleges, Associations and Unions, Educators, and other stakeholders, will establish a single provincial Health Human Resource Framework that will be used to plan, link and coordinate go-forward actions and initiatives.
- British Columbia has the fastest growing senior's population in Canada. The number of seniors in BC is expected to almost double by 2036, and the 75+ population will grow by almost 130 per cent over the same time. While the majority of seniors are comparatively healthy and have few serious health concerns, others within this age cohort are not as fortunate.
- Residential care accounts for, by far, the majority of expenditures in this area. Although frail seniors in residential care represent only one per cent of the population, they use 21 per cent of all health system expenditures included in the matrix. A large driver of this cost is the provision of 24/7 residential care.

- British Columbia's 303 residential care homes are home to almost 42,000 residents, with an average age of 85 years. Many of these residents have one of more chronic conditions at varying levels of severity. For example, 61.4 per cent have dementia and 20.2 per cent have diabetes. In addition, 6.7 per cent have cancer while almost one-third have severe cognitive impairment. These seniors require a wide range of health supports to help manage such medical challenges, which are often what precipitated the entry into residential care in the first place.
- It is to say the obvious that most seniors prefer to remain in their homes and communities rather than move to a care home. When community care provides a viable alternative, client experience is enhanced. When seniors are admitted to acute care, they can experience prolonged periods of inactivity during which time their level of functional ability is reduced and may never recover. The quality of life is better when an individual is able to be sustained in their home and community.
- The per-person cost of caring for a frail senior through home and community support is less than half the cost of caring for them in residential care (e.g., residential care: $59,210; community: $20,290; community with high chronic condition: $29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in residential care7 (i.e., 18 per cent for frail seniors living in the community versus 7.1 per cent for those living in residential care).
- In 2015/16, Regional Health Authorities will develop three-year local community plans for all rural and remote communities to create environments that foster healthy behaviours and programming that improves the health of the population. These plans will be developed in collaboration with local communities. The plans will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers.
- By September 30, 2015, each of the Regional Health Authorities will provide an assessment of the status of primary and community care services across all rural, small rural and remote communities and a specific three-year plan on how they intend to move forward with this policy direction as a region. This plan will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers. It is recognized that this process will take time and engagement.
- Home Support and Residential Care in Rural Communities (Section 2.2): In collaboration with communities and clients, Regional Health Authorities will initiate work on exploring innovative and cost effective service options to better support ageing in place but also clarity on residential care options for when they are required to allow active preplanning by older adults and their families. This work will be reported in their Service Plans, be available on the health authority web site and attached to their Detailed Service and Operational Working Papers starting 2015/16.
- The Provincial Surgery Executive Committee (PSEC) has been given the mandate and authority to drive a common vision and a comprehensive policy framework, inclusive of the entire surgical care continuum, that gives priority to improving the quality of surgical services and embed the philosophy of patient centered care into strategic and operational processes. PSEC will facilitate collaborative partnerships between patients, health authorities, physicians, the Ministry of Health, the BC Patient Safety Quality Council, the Doctors of BC and other relevant nursing and allied health stakeholders.

Re: BC Care Providers Association (BCCPA) response to Ministry of Health Policy Papers

The BC Care Providers Association (BCCPA) would like to thank the Ministry of Health once again for hosting an important dialogue with service providers on March 25, 2015. The BCCPA believes this constructive dialogue must also continue particularly through the establishment of a new Continuing Care Collaborative.

Likewise, the BCCPA also looks forward to participating in the Primary and Community Care Forum organized by the Ministry of Health on June 1st and 2nd in Vancouver.

Overall the papers do a good job in identifying key population areas including caring for the frail elderly and chronically ill. They also deal with significant other populations including those with mental health issues particularly dementia. Following a review of the Ministry papers, the BCCPA agrees with a number of recommendations. In particular, some of the potential positive points and/or opportunities as outlined in the papers include:

- Protection of existing expenditures in primary and community care while reallocating funding away from more costly acute care.
- Openness by the Ministry of Health to engage with various stakeholders on the ideas presented in the paper, including a review of major primary and community care policy.
- Development of new Dementia Action Plan, in which the BCCPA is currently providing input on.
- Implementation of the End-of-Life Care Action Plan, including commitments to double number of hospice spaces by 2020.
- Exploring how other jurisdictions fund home support, assisted living and residential care services as well as further dialogue with health authorities and major stakeholders on how to provide services.
- Highlighting alternate level of care (ALC) beds issue including opportunities to increase planned admissions to residential care rather than admissions through the ER and in-hospital bed use.
- Having single oversight and shared governance model for primary and community care that includes representation from key players involved in primary and community care.

Some of the potential concerns as outlined in the documents include the overt focus to reduce residential care services with greater home care. In particular, the Primary and Community Care Paper notes BC utilization and current funding approaches to residential care services are suboptimal and that there are opportunities to provide support services to clients both in community and AL units to reduce need for residential care. The paper also notes a couple of times senior's strong preference to remain in their homes and communities rather than move to a care home.

Although younger seniors may prefer to age in place this may change as they get older. As a result, the BCCPA suggests undertaking a research project to review how a senior's preference for ageing in place or at home may change over time depending on their specific age and/or level of acuity. In addition, there should be further studies on the costs of home care versus long-term care for seniors as their levels of acuity rise.

Along with the earlier concerns about ensuring seniors with higher levels of acuity are cared for appropriately, it will be important that stakeholders including BCCPA are involved in any process or assessment with respect to changing the delivery of rural health services for seniors. Other positions, although not specifically outlined in the papers, that the BCCPA would like to put forward for consideration include:

Increased collaboration

- Establishing a new *BC Continuing Care Collaborative* involving the Health Authorities, Ministry of Health, Denominational Health Association and the BC Care Providers Association.
- Reintroduce the Managing Changing Need Policy as part of BC's Home and Community Care Policy Manual or at minimum ensure that similar provisions exist elsewhere.

Review of funding lifts and Direct Care Hours

- Working in consultation with operators and health authorities to develop a residential care funding model that accurately factors in increases to operating costs including a standard province-wide methodology on how base funding and/or annual funding increases are calculated for contracted service care providers.
- Reviewing funding lifts within Health Authorities with the goal of consistency, fairness and sustainability with respect to per diem rates, including as outlined in the 2012 Ombudsperson report, working with the Health Authorities to conduct an evaluation on whether residential care budgets are sufficient to meet the current needs of the population.
- Development of a continuing care funding model that is responsive to and appropriate to the acuity and complexity of clients in care as well as adheres to the core principles of timeliness, sustainability, equity and transparency.
- Establishment of a long-term predictable funding model by end of fiscal 2018 that is outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3 to 5 year period.
- Reviewing Direct Care Hours (DCH) provided per resident to ensure greater consistency among care homes and more fairness in the provision of care to clients across the sector. This includes providing care operators with greater flexibility to manage their DCH over a reasonable period of time, namely at minimum on an annual basis as opposed to quarterly.

Review of new funding models

- Reviewing further the concept of long-term care insurance to address issues of an ageing population and increasing continuing care expenditures.
- Explore use of vouchers including whether it could be provided to seniors to pay for continuing care, including residential care, home care and assisted living services in lieu of government provision of such services.
- Provide clearer lines of responsibility and accountability to taxpayers and residents by separating bodies that regulate care homes and that provide and allocate funds from those that operate them.

Better Dementia and Palliative Care

- Development of a program to better integrate residential care homes as part of any age friendly community approaches, including Dementia Friendly Communities with funding to retrofit existing care homes to support such an approach.
- Development of a dementia friendly care home program in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate dementia residents and/or where specific dementia training has been provided to staff.
- Endorsement of a National Dementia Strategy with federal participation which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.
- Adoption of new palliative care models including where necessary providing funding to improve the integration between long-term and end-of-life care, including new long-term care models with expanded roles in caring for seniors.

Improving Seniors Safety and Quality Care

- Funding to support use of technology and the existing residential care infrastructure to facilitate seniors care ageing in place or reducing social isolation of seniors (i.e. home health monitoring, increasing

internet access for seniors and seniors drop in centres) as well adoption of new technologies that improve the safety of seniors (i.e. new monitoring and surveillance systems).

- Implement legislation that allows patient information to flow through the health care system with the resident particularly the sharing of information after a return from a hospital stay.
- Advancement of a collaborative Seniors Safety agenda which could focus on specific issues including falls prevention, resident on resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety in home and community care homes.
- Development of a provincial coordinated strategy to deal with workplace injuries in the continuing care sector including dedicated funding to install patient lifts and other retrofits to residential care homes across BC.

Appendix B: Types of Home and Community Care Support

Organization of Home and Community Care in British Columbia

In 1978, the British Columbia (BC) government introduced coverage of home nursing care and residential care services followed by the subsidization of home support services in 1981. While the BC Ministry of Health is largely responsible for providing the overall strategic direction and allocation of funds to health authorities, the five regional health authorities directly deliver programs and contract with private for-profit and non-profit agencies to provide services. In particular, Health Authorities are responsible for: delivering programs that are consistent with Home and Community Care (HCC) policies and standards; ensuring operational policies and procedures are in place; planning and monitoring services at regional level; and reporting on their performance.[75]

The Health Authorities develop their budget from the allocation provided and in part based on Ministry's priorities as outlined in the Government Letters of Expectation. In total, the Health authorities expected to spend over $2.5 billion on home and community care in 2011/12 – an increase of 60 per cent from 2001 or about 20% to 30% of their budgets.[76] As of March 31, 2013, BC has approximately 31,500 publicly subsidized residential, assisted living and group home beds.[77] This is a 24 per cent increase since June 2001 of over 6,000 beds.[78]

Type of Support	Services / Supports Received
Home Support (includes personal assistance with daily activities, such as bathing, dressing, grooming and light household tasks).	• Subsidized services may be provided by employees of health authorities or by other organizations, either non-profit or for-profit, with which a health authority has made a contract. • Seniors who do not qualify for subsidized home support services may opt to privately purchase various services that are similar in nature to subsidized home support services. • This includes programs such as Better at Home and Home is Best.
Home health care	• Professional health services delivered in the home such as nursing care, physiotherapy, and occupational therapy. • Health authorities spent almost $754 million on home health services in 2011/12 – an increase of almost 86 per cent since 2001.
Assisted Living (i.e. publicly subsidized apartments with support services for frail seniors and people with disabilities. Housing, meals, laundry, housekeeping, and some personal care services are provided. Nursing	• Assisted living residences can be owned and operated by health authorities, non-profit groups or private companies. • Individual care homes may contain only subsidized units, only non-subsidized units or both.

[75] BC Auditor General Report. Home and Community Care Services: Meeting Needs and Preparing for the Future. October 2008. Accessed at: http://www.bcauditor.com/pubs/2008/report7/home-and-community-care-services-meeting-needs-and-prepar. In addition to the health authorities, a number of private operators deliver residential care, assisted living and other services to British Columbia residents who pay directly for the services. These operators are not publicly subsidized and the users of the services pay the full costs.

[76] In 2011/12, the health authorities spent $943 million for services that provide home support, community nursing and rehabilitation services for assisted living and adult day programs. In 2011/12, health authorities spent $1.7 billion on care homes that provide 24-hour professional nursing care and supervision for seniors who have complex care needs and can no longer be cared for in their own homes. Thus, the health authorities spent over $2.6 billion on home and community care in 2011/12 (see: http://www.bcauditor.com/healthfundingexplained).

[77] Ministry of Health. Home and Community Care Beds Inventory. March 2013.

[78] BC Seniors Action Plan. February 2012. Accessed at http://www2.gov.bc.ca/assets/gov/topic/AE132538BBF7FAA2EF5129B860EFAA4E/pdf/seniorsactionplan.pdf

care is not provided but is a 24-hour emergency response system in place).	• Health authorities administer subsidized assisted living services, overseen by the Ministry of Health. • Private companies and some non-profit groups provide non-subsidized assisted living services.[79]
Residential care homes (24- hour professional nursing care and supervision in a care home)	• Subsidized residential care services are part of the provincial home and community care program, which is overseen by the Ministry of Health and delivered by the health authorities. • In some cases, subsidized services are delivered directly by health authority employees and, in others, by non-profit or for-profit agencies under contract with a health authority. • One hundred and twelve or 32 per cent of residential care homes are owned and operated by the health authorities. The remaining 236 or 68 per cent are operated by private operators. • Seniors who can afford to do so can also arrange to receive services directly from a private provider. [80]

Residential Care

Residential or long-term care in BC is provided in Residential Care homes (RCHs). RCHs provide nursing care and supervision for people with complex health care needs who can no longer live independently in their own homes or in another setting. Residents in RCHs cannot remain in their homes due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care, and/or supervision. Long-term residential care services provide 24-hour professional supervision and care in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence. Long-term residential care services include:

- Standard accommodation;
- Development and maintenance of a care plan;
- Clinical support services (i.e. rehab and social work services as identified in care plan);
- Ongoing, planned physical, social and recreational activities, such as exercise or music programs, crafts, games;
- Meals, including therapeutic diets if prescribed by a physician, and tube feeding;
- Meal replacements and nutrition supplements as specified in care plan or by a physician;
- Routine laundry service for bed linens, towels, washcloths, and all articles of clothing that can be washed without special attention to the laundering process;
- General hygiene supplies, including but not limited to soap, shampoo, toilet tissue, and special products required for use with care home bathing equipment;

[79] Ombudsperson Report. The Best of Care: Getting It Right for Seniors in British Columbia (Part 2) - Public Report No. 47. Accessed at: https://www.ombudsman.bc.ca/investigations/systemic-investigations/systemic-investigations-completed-in-2011-12/137-public-report-no47-the-best-of-care-getting-it-right-for-seniors-in-british-columbia-part-2

[80] Premier's Council on Aging and Seniors' Issues. Aging well in British Columbia: report of the Premier's Council on Aging and Seniors' Issues. 2006. Accessed at: http://www2.gov.bc.ca/assets/gov/people/seniors/about-seniorsbc/pdf/aging_well_in_bc.pdf; and BCMA. Bridging the Islands: Re-building BC's home and community care system. May 2008. Accessed at: https://www.doctorsofbc.ca/sites/default/files/hcc_paper.pdf

- Routine medical supplies;
- Incontinence management; and
- Any other specialized service (such as specialized dementia or palliative care) as needed by the client that the service provider has been contracted to provide.
- British Columbia's 303 residential care homes are home to approximately 42,000 residents, with an average age of 85 years. Many of these residents have one or more chronic conditions at varying levels of severity. For example, 61.4 % have dementia and 20.2% have diabetes. In addition, 6.7% have cancer while almost one-third have severe cognitive impairment.

Residential Care in British Columbia	
Number of Residents	41,619
Average age	85
Younger than 65 (%)	5.2
85 and older (%)	58.7
Female	65.3
Diagnosis of Dementia (%)	61.4
Diagnosis of Hypertension (%)	45.9
Diagnosis of Cancer (%)	6.7
Diagnosis of Diabetes (%)	20.2
Severe Cognitive Impairment (%)	32.6
Signs of Depression (%)	21.4
Daily Pain (%)	20.6
Some aggressive behavior (%)	34.5
1+ ER Visits (%)	7.1
1+ Admissions to Hospitals (%)	6

Assisted Living

Assisted Living is a relatively new form of care in British Columbia and is a middle option between independent living (with some limited support) in one's own home, and living in a residential care home. First established in 2002, assisted living is a care setting that combines publicly subsidized apartments with support services for frail seniors and people with disabilities who can no longer live at home, yet do not require the 24-hour professional care and supervision provided in residential care homes

Assisted living residences can range from a unit in a high-rise apartment complex to a private home. Units can vary from one room to private, self-contained apartments. Residents pay an inclusive fee for which they receive room, board, meals, weekly laundry, and housekeeping and only one or two prescribed personal care services to assist with the activities of daily living. Additional services are paid for out of pocket by the residents or their families. Nursing care is not provided but there is a 24-hour emergency response system in place. In BC, residents pay 70 per cent of their after-tax income for publicly-funded assisted living services and are responsible for cost of other services they would normally pay for if they lived in own home.[81]

According to a 2012 study, half of Assisted Living residents are 85 or over, three-quarters are female, and about half subsequently move on to residential care. Approximately a quarter of people leave Assisted Living

[81] Centre for Health Services and Policy Research. Home Health Services in BC: A Portrait of Users and Trends Over Time. Kim McGrail et al. October 2008. Accessed at: http://www.chspr.ubc.ca/sites/default/files/publication_files/chspr08-15.pdf

after less than one year.[82] Only one-third of people who die do so in Assisted Living, suggesting a possible need for more attention to end of life care in this type of care setting.[83]

BC was the first province in Canada to regulate Assisted Living residences. By law, Assisted Living operators must offer five hospitality services: one to three meals a day plus snacks; light housekeeping once a week; laundering of flat linens once a week; social and recreational opportunities; and a 24-hour emergency response system. As of March 2016, they must also provide at least one, and not more than two, of six "prescribed services," which as outlined in the Community Care and Assisted Living Act are:

- Regular assistance with activities of daily living (i.e. eating; mobility, dressing, etc.);
- Medication management;
- Personal financial management;
- Monitoring of food intake;
- Structured behaviour management and intervention and
- Psychosocial rehabilitative therapy or intensive physical rehabilitative.[84]

According to a recent report from the Seniors Advocate BC entitled *Seniors Housing in BC: Affordable, Appropriate, Available*[85] as of March 2014 BC has about 23,000 assisted living units including 4,400 that are subsidized while the remaining are private registered (3,200) or private non-registered (15,200). As also outlined in the Seniors Advocate report, it recommends that registered AL be fundamentally redesigned and regulations changed, to allow for a greater range of seniors to be accommodated and age in place as much as possible, including palliative care.[86]

As of March 2016 and as outlined under the Community Care and Assisted Living Act (CCALA), registered Assisted Living operators must nominate two of six prescribed services that will be offered to residents. The two most commonly prescribed services offered by AL operators are: assistance with the activities of daily living, and central storage/distribution of medications.

In particular, if a resident requires one or more of the other four prescribed services, their care will be deemed as too complex for Registered AL and a discharge plan will be implemented or, in the case of a senior attempting to move in, the move will not occur. On March 8, 2016 the BC government announced that it would be making changes to the CCALA to deal with this issue.

Home Support Programs in British Columbia

Home Support provides assistance with the tasks of daily living for people with chronic illnesses, disabilities, or progressive medical conditions. Home support workers provide personal assistance with daily activities,

[82] Just over one-half (51%) of all Assisted Living residents eventually move to residential care homwa. One-half of those move directly from Assisted Living to residential care, while the other half seem to be triggered to move to residential care following a hospital stay. Another 34% of Assisted Living clients die: 11% die in Assisted Living, 22% die after being admitted to hospital, and 1% die within 30 days of admission to residential care. A full 15% of Assisted Living residents appear to move back to the community: one-third of those with community based home health services, and two-thirds without any publicly-funded services.

[83] Centre for Health Services and Policy Research. Who uses Assisted Living in BC: An Initial Exploration. April 2012. Kim McGrail et al. Accessed at: http://www.chspr.ubc.ca/sites/default/files/publication_files/assistedliving.pdf

[84] Ibid.

[85] Seniors' Housing in BC: Affordable, Appropriate, Available. BC Office of the Seniors Advocate. May 2015. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/05/Seniors-Housing-in-B.C.-Affordable-Appropriate-Available.pdf

[86] The Seniors Advocate report also notes that provinces such as Alberta and Ontario do not have the prescribed services model of B.C. and allow for more flexibility in assisted living type residences, thus, explaining in part why they find that, based on comparative residential care assessments, there are seniors living in residential care in British Columbia who would be living either in the assisted living equivalent or the community if they lived in Alberta or Ontario.

such as bathing, dressing, grooming, and light household tasks, that allow clients to stay in their homes for as long as possible. Access to publicly subsidized home support services is based on an assessment by Health Authorities. Eligible clients using publicly funded home support services are charged a daily rate based on their after-tax income. These services may also be purchased privately. About 73% of people receiving home support services pay no fee due to their low incomes.

In 2009/10, there were at least 24,500 seniors receiving subsidized long-term home support services in British Columbia. In 2009/10, the regional health authorities spent a total of approximately $339 million providing subsidized home support services throughout the province. It typically costs the health authorities $30 to $40 to provide each hour of subsidized home support. As outlined in the recent Seniors Advocate report entitled Monitoring Seniors' Services (2015):

- In 2014/15, a total of 85, 251 clients received home support services in BC, an increase of 3% over 2013/14. Similarly, the number of home care visits increased by 5% to a total of 1,090,111 visits;
- In 2014/15, a total number of 41,233 clients were registered for publically subsidized home support, while the total number of home support hours provided was 11,067,925; and
- The number of home support hours is trending down in three out of five health authorities, while the number of clients has increased in four out of five (discrepancy greatest in NHA).

Better at Home

Better at Home, is a program funded by the BC government and managed by the United Way of the Lower Mainland (UWLM) to support BC seniors to remain in their own homes longer by giving them access to non-medical services such as transportation to appointments, light housekeeping and yard work, minor home repairs and friendly visiting. Better at Home is being implemented in over 65 communities around the province.

Better at Home builds on the Community Action for Seniors' Independence (CASI) pilot initiative, a partnership between the UWLM and the BC government, which has offered simple non-medical support services to more than 1,000 seniors in five pilot communities. The findings from the CASI final evaluation, (November 2012), showed a high level of satisfaction with the program from CASI clients, service providers and community leaders, and indicated that the provision of non-medical home support services is having a positive impact on the lives of seniors and their families in the pilot communities.[87]

Development of the Better at Home program began in April 2012. Services are provided by local non-profit organizations selected through a community engagement process, which includes local seniors. The services are delivered by a mix of volunteers and paid workers. The BC government has provided $20 million to the UWLM to develop implement and manage the program. The UWLM, in turn, funds local non-profit organizations to deliver services. The goals of the program are to help seniors live independently and remain connected to the community. Better at Home supports all the age friendly community domains but particularly the following domains: transportation; respect and social inclusion; and community support and health services.

[87] The CASI evaluation recommendations, which have been incorporated into the Better at Home program, focused on the need for: training for project coordinators, and service providers; a provincial leadership committee to oversee implementation of the program; a continued community development approach; avenues for sharing information/best practices; and ongoing planning and evaluation.

Home is Best / Home First

Providing care to individuals in their home rather than acute and residential care is designed to better support clients, their families and caregivers. Under the Home is Best program, in-home care supports are tailored to an individual's need. Home support care can include bathing and washing, dressing, grooming, taking medication and other personal care needs. The goal is to keep people out of acute and residential care as well as to help seniors live safely at home and avoid future hospital emergency admissions. This program has had a positive impact on the target audience with fewer admissions to acute and residential care as noted in the quarterly reports by health authorities.

In March 2013, the BC government as part of an annual funding announcement of $50 million over the next three years for targeted primary and community care programs noted that the Home is Best Program would be rolled out in all five health authorities. The program, which was piloted in Vancouver Coastal Health's North Shore and in Fraser Health, has shown some positive results. In Vancouver Coastal, the program resulted in a 30 per cent decrease in acute care use, and a 25 per cent reduction in emergency department visits.[88]

[88] B.C. continues to expand primary and community care. March 1, 2013. http://www.newsroom.gov.bc.ca/2013/03/bc-continues-to-expand-primary-and-community-care.html

Appendix C: BCCPA AGM Funding Resolution (2015)

Special Resolution: Annual General Meeting – May 25th

WHEREAS there is no standard province-wide methodology used by health authorities regarding how base funding and/or annual funding increases are calculated for contracted service care providers; and

WHEREAS there are no consistent province-wide standards linking funding to the level of acuity and medical complexity of seniors in care; and

WHEREAS the funding of direct care hours for seniors with similar medical conditions varies widely between Health Authorities, within a health authority or a campus of care; and

WHEREAS it has become increasingly challenging for our residential care and contracted home support members to remain fiscally sustainable due to an identified shortage of funding to cover inflationary costs; and

WHEREAS it adds undue financial stress and operational challenges for our care providers who are unaware of what their final operating revenues will be, relative to their budgets, until well into the fiscal year the services are being delivered; and

WHEREAS it facilitates better planning and is considered best practice for service providers to be advised in a timely manner what their budget is prior to the beginning of the fiscal year; and

WHEREAS the Ministry of Health and Health Authorities have agreed in principle with the need to establish a formal platform for collaborative dialogue.

Therefore, be it resolved that the BCCPA write to the Ministry of Health requesting the following;

- That the Ministry of Health and Health Authorities formally establish a new BC Continuing Care Collaborative to help improve health outcomes for seniors and further enhance partnerships, dialogue and planning between government, health authorities and service providers.
- The Continuing Care Collaborative should have senior level representatives from the Ministry of Health, the Health Authorities, the BC Care Providers Association and the Denominational Health Association.
- The first meeting of the Continuing Care Collaborative should take place by October 2015.

Therefore, be it further resolved that;

The *Continuing Care Collaborative* establish as one of its priorities the adoption of four core principles that would help establish a stronger and effective functional partnership between contracted providers and the health authorities. These principles would be adhered to in a consistent manner across the province.

Timeliness:

- Health Authorities will aim to provide care providers in writing with their funding notice prior to March 31st but no later than 90 days after the start of the fiscal year on April 1st.

Fiscal Sustainability:

- Contracted care providers are provided the necessary funding to cover identified year-over-year costs related to inflation and/or enhanced service delivery requirements in order to ensure they remain financially whole.

Equity:

- The calculation of funding lifts and direct care hours is consistent within and across health authorities.

Communication and Transparency:

- Contracted service providers are provided with timely and appropriate communication regarding any significant issue related to their funding relationship with the health authority;
- The methodology used to calculate annual funding lifts will be shared openly with care providers.

Appendix D: Direct Care Hours Motion for the 2016 BCCPA AGM

Direct Care Hours

WHEREAS significant disparities exist in British Columbia (BC) with respect to Direct Care Hours (DCH) among care homes within and between Health Authorities and such disparities makes it difficult to provide equal and consistent levels of care leaving some residents at a disadvantage over others; and

WHEREAS the funding of direct care hours for seniors with similar medical conditions varies widely between Health Authorities, within a health authority or a campus of care; and

WHEREAS the BC Ministry of Health has indicated as a 3.36 hours of direct care provided per day per resident (3.00 hours nursing and 0.36 allied, or supporting, care) as a guide for health authorities;[89] *and*

WHEREAS moving to a more consistently applied DCH will require a better understanding with regards to how services are delivered, by whom, at what time of the day, the client load of the staff, the quality and training level of the service provider, the BCCPA recommends:

- Health Authorities provide greater transparency with respect to how DCH for residential care are determined, including outlining how changes are derived as part of any funding model and involving operators in the process so they are prepared well in advance of any changes.
- That the required DCH provided per resident be reviewed at a minimum on an annual basis across all health authorities to ensure greater consistency among care homes and more fairness in the provision of care to clients across the sector.
- As staffing levels fluctuate throughout the fiscal year, care operators be given the flexibility to manage their DCH over a reasonable period of time, namely annually as opposed to quarterly.
- Any increases in DCH requirements be fully funded by the Health Authorities and as outlined in the 2015 BCCPA Policy Paper *Quality-Innovation-Collaboration* some of the funding redirected from acute care to home and community care go directly to care homes, including new Continuing Care Hubs to meet current and future DCH requirements.
- Where feasible, the province move towards a standard of 3.36 hours of care per resident per day and that any necessary staffing increases to meet this requirement be fully funded by Health Authorities and/or Ministry of Health.
- That there should be a standard definition for DCH that includes RNs, LPNs, Care Aides as well as other allied health professionals and activity staff, and that clinical support provided by Directors of Care (DOC), assistant DOC, and clinical coordinators be included consistently in the calculation of DCH. In particular, the professional support component of DCH should include those occupations outlined in the Health Professions Act.

[89] Home and Community Care Program, "Costing Assumptions #3 for the Proposed Staffing Framework for Residential Care Facilities," 11 August 2009, 1; and Home and Community Care Program, "Residential Care Staffing and Reporting Tool Frequently Asked Questions," internal document, 3.

Appendix E: Long Term Care Insurance

Quebec

By 2031, Quebec seniors will comprise around 25% of the population, almost double current levels. During the next 20 years, the number of Quebecers aged 75 and more will also double, while the increase in those aged 85 and older will be 107%. In 2011/12, 4.3 billion dollars were spent on long-term service programs, not counting amounts paid by the Health Insurance and Prescription Drug Insurance schemes or administrative and fixed asset costs[90].

To meet these fiscal challenges, Quebec had indicated plans to introduce a program of tax-based insurance for long-term care that it is calling 'Autonomy Insurance.' This program will extend scope of the current medicare program to the currently uninsured, or at best partly insured, domains of home and long-term care. The program will be financed out of the general tax system but with the money being set aside in a separate and protected fund, as currently done with Quebec's automobile insurance fund.

Accordingly, the program would have begin on a pay-as-you-go basis. Coverage will be universal, independent of income, and applicable both to the elderly and to younger people with disabilities. Benefits will be tailored to the needs of each individual through a system of scientific needs assessment and will be provided by a combination of public and contractually based private providers with some allowance, in exceptional circumstances, for in-cash private caregivers. Some co-payments by recipients of care may be required. The program, like the current medicare and automobile insurance systems, will be managed by a dedicated public agency.

In May of 2013, the Quebec government released its White Paper on Autonomy Insurance. As noted in the report a fall parliamentary committee will then be followed by a draft bill on the parameters of this insurance plan, which it hopes to implement in the spring of 2014. As noted in the paper, funding autonomy insurance will take place in two stages. In the first four years (fiscal 2014-2015 through 2017-2018), autonomy insurance will use current fiscal cost framework, with the following components:

- The annual amount available for long-term services comprised of previous fiscal year funding, indexed in accordance with the parameters of the government's fiscal cost framework and government commitments to home support, which comes to 500 million dollars spread over fiscal years until 2017-2018
- User fees corresponding to the non-refundable Tax Credit for Home-Support Services for Seniors, to amounts users are required to pay under FAPDHS and a portion of the contribution for adults that live in CHSLD environments.
- Fiscal expenditures equal to rise in Tax Credit for Home-Support Services for Seniors

Germany

Germany's universal multi-player health care system has 90 per cent of the population covered by statutory health insurance, with the remaining citizens with higher income or who are self-employed using private health insurance. For home care, Germany uses quasi-market mechanisms to increase competition with providers and to promote quality and choice and reduce costs. For example, if a person is eligible for long-term care insurance, he/she can choose to: receive a payment in cash, have a package of care services in-kind

[90] Quebec Government. Report from the Committee on Health and Social Services. Autonomy for All: White Paper on the Creation of Autonomy Insurance. 2013. Accessed at: http://www.assnat.qc.ca/en/travaux-parlementaires/commissions/csss/mandats/Mandat-24161/index.html

delivered by an agency, or combine the two options. Germany freezes benefit levels so that as costs rise, the increasing gap that develops is met by individual contributions.[91]

Under its LTC insurance program, eligibility is not based on age, but almost 80 per cent of beneficiaries are 65 years old or older. Recipients are categorized according to three levels of dependency. According to the latest figures, of Germany's 82 million people, roughly 79 million have some form of long term care insurance (roughly 88 per cent are public and 12 per cent private). Most beneficiaries of Germany's long term care insurance stay at home (69 per cent) and can opt for a monthly cash payment – in 2012 between €235 (US$ 300) and €700 (US$ 930) – to cover their care needs or can receive in-kind benefits – in 2012 between €450 (US$ 600) and €1550 (US$ 2065) – in the form of professional care services. People can also give the money to a caregiver friend or relative.

For the remaining 31 per cent of beneficiaries living in care, these payments only cover a portion of the monthly cost of nursing home care. If they can, recipients supplement the long term care insurance with other insurance or pension schemes. If they can't, their families are obliged to step in and, if not, recipients must apply for social assistance as a last resort.[92]

England

In light of an ageing population in England (number of people aged over 85 will double by 2030), plans are underway to create a universal state-backed insurance system for elderly care, which aims to cap costs for one in eight pensioners and cut bills for the wealthy. The social insurance scheme will have elderly people pay premiums, depending on their wealth and whether they receive care in the home or in a care home. Costs per person will be capped at $110,000 (US). The plan is designed to support those with lower socioeconomic status and people who are qualified for care, but in past were considered too wealthy to get social support.[93]

Denmark

The Danish long-term care system for the elderly and people with disabilities provides comprehensive coverage for a wide-range of social services, including home adaptation, assistive devices and home care. Home care services include support towards technical aids and equipment, and even activities outside of the beneficiary's home that sustain the individual's participation in activities of daily living. Local authorities finance the costs of long-term care through block grants received from the government, local taxes and equalisation amounts received from other local authorities.

The overall budget for long-term care services is global, and is set annually. Legislation allows local authorities some limited freedom in setting charges for home help and some other non-health related expenses. Thus, user charges only account for a small part of the total long-term care expenses (out-of-pocket payments account about 10 per cent of total long-term care expenditure). Local authorities may issue a service certificate to private providers meeting quality standards, allowing individuals to employ his/her own personal helper from among qualified individuals and companies.[94]

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[91] Ontario Association of Community Care Access Centres. Health Comes Home: A Conversation about the Future of Care. January 2014. Accessed at: http://oaccac.com/News/Lists/PublicationsDocument/HealthComesHomePart1.pdf

[92] KPMG. An Uncertain Age: Reimagining Long-Term Care in the 21st Century. June 25, 2013. Accessed at: https://www.kpmg.com/TW/zh/IssuesAndInsights/Articles-and-Publications/Documents/2013-kpmgbiotech-tl/an-uncertain-age-2013.pdf

[93] Ontario Association of Community Care Access Centres. Health Comes Home: A Conversation about the Future of Care. January 2014. Accessed at: http://oaccac.com/News/Lists/PublicationsDocument/HealthComesHomePart1.pdf

[94] OECD. Denmark: Long-Term Care. May 2011. Accessed at: http://www.oecd.org/denmark/47877588.pdf

Sweden

Sweden allocates five times the EU average to elder care, making it the highest investment of GDP in elder care in the world. Of Sweden's 9.5 million inhabitants, 18 per cent have passed the retirement age of 65. This number is projected to rise to 30 per cent by 2030. Of the SEK 95.9 billion, (USD 14.0 billion, EUR 10.7 billion) cost of elder care – only three per cent of the costs are financed by client charges. Most elderly care is funded by municipal taxes and government grants. Each municipality decides its own rates for elderly care. The cost depends on the level or type of help provided, and the person's income. A maximum charge for home help, daytime activities, and certain other kinds of care has been established. More municipalities are privatizing parts of their elderly care. In 2011, private care provided services for 18.6 per cent of all elderly people getting home help. Recipients can choose whether they want their home help or special housing to be provided by public or private operators.[95]

Japan

Japan introduced mandatory long term care insurance in 2000, which made long term care an entitlement for all older people over 65 or those who are 40-65 and have been disabled by Alzheimer's or stroke (Tsutsui and Muramatsu, 2007; Imai et al, 2008). The system is funded from a variety of sources, including 10% co-payments from service users and the remaining 90% of costs being split between insurance premiums paid by all Japanese people over 40 and local and regional taxes (Tsutsui and Muramatsu, 2007).[96]

The first review of its LTC insurance program occurred in 2005 and aimed to reduce escalating costs as well as improve services to older people (Tsutsui and Muramatsu, 2007; Imai, 2008). The overarching aim was to refocus the LTCI system from institutional to community based care in recognition of the fact that it originally incentivised people to go into more costly long-term care homes rather than stay at home and receive community based services, as the cost of long term care was highly subsidised for care home residents (Tsutsui and Muramatsu, 2007; Imai et al, 2008). The key measures of the 2005 reform were to implement "hotel costs" for long-term care homes and introduce more preventative services for older people living in their own homes (Tsutsui and Muramatsu, 2007; Imai et al, 2008).[97]

In 2012, Japan introduced a new integrated Community-based Care System targeted at ageing baby boomers. This concept aims to provide various support services, including welfare, healthcare, long term care and preventative measures within existing communities, accessible within 30 minutes. As a first step, there are 24-hour home visit services, which can also be reimbursed under the national long term care insurance scheme. Senior housing developments now have safety monitoring and other services that are subsidized by the government.[98]

[95] Elderly Care in Sweden. Accessed at: http://www.sweden.se/eng/Home/Society/Elderly-care/Facts/Elderly-care/

[96] International Longevity Centre. Ageing, Health and Innovation: Policy Reforms to Facilitate Healthy and Active Ageing in OECD Countries. 2011. Accessed at: https://www.dcu.ie/sites/default/files/afu/ageing_health_innovation_oecd.pdf

[97] International Longevity Centre. Ageing, Health and Innovation: Policy Reforms to Facilitate Healthy and Active Ageing in OECD Countries. 2011. Accessed at: https://www.dcu.ie/sites/default/files/afu/ageing_health_innovation_oecd.pdf

[98] KPMG Report. An Uncertain Age: Reimagining Long-Term Care in the 21st Century. June 25, 2013. Accessed at: https://www.kpmg.com/TW/zh/IssuesAndInsights/Articles-and-Publications/Documents/2013-kpmgbiotech-tl/an-uncertain-age-2013.pdf

Appendix F: Use of Vouchers in European Countries

Various countries in Europe such as France, Germany, Sweden, Finland, Denmark and Italy currently use vouchers to assist clients with costs of home and community care. As noted in report from CD Howe (2016) countries like Germany have been more inclined to give cash benefits for continuing care with few restrictions, but have set the size of the cash benefit below the value of in kind services as a way of steering individuals toward the in-kind option. In contrast, France and other countries, such as Japan, give cash benefits but with greater restrictions. Canada, however, is unique in offering little choice and largely restricting provision to services in kind.[99]

The French Example: Cash Payments Based on Needs and Income

In 2002, France introduced an allocation personalisée d'autonomie (APA, personal autonomy allowance) for individuals needing help with activities of daily life and limited independence. APA is universally available for those ages 60 and older who have long-term-care needs and live either at home or in long term care. For home-care needs, APA provides support for services deemed necessary by case evaluators, which includes financial support for caregivers, excluding a spouse or partner. For those in long-term care, the APA pays for a portion of the costs; the resident pays the remainder either out of pocket or through private insurance. The size of the allowance increases with the clients' assessed level of dependence and decreases with rising income. Maximum monthly benefits are roughly €1,300, or $1,600.

The German Example: The Choice between In-Kind or Cash Benefits

In Germany, once qualifying for public coverage of long-term care, a beneficiary must decide, every six months, between receiving benefits in kind, in cash, or as a combination of both. Allowing clients to choose between in-kind care and a cash payment stems from concerns that individuals might misuse cash benefits; hence, the level of cash payments is set lower than the costs of providing in-kind services, which nudges clients toward in-kind care. Since this plan was introduced, more individuals have chosen to receive their care in kind rather than in cash. Subject to co-payments, cash and in-kind benefits are offered according to need, with three levels of care, and the same level of benefits regardless of income. Formal in-kind care providers are almost entirely private for-profit and not-for-profit, and are offered contracts that are reviewed annually.

The Nordic Countries' Example: Vouchers for Services

In Sweden, Finland, and Denmark persons in LTC receive vouchers with which they may choose among providers of a restricted set of services, either in home care or in institutional care. In Finland, the size of the voucher depends on household composition and income and clients pay the difference between the size of the voucher and the cost of services; as well, vouchers cannot discriminate between providers. In Denmark, however, each provider must meet minimum standards to qualify among a potential group of eligible caregivers.

[99] CD Howe Institute. Commentary No. 443. Ake Blomqvist and Colin Busby. Shifting Towards Autonomy: A Continuing Care Model for Canada. 2016. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_443.pdf

In Sweden the LOV (Lag om valfrihet or Legislation on Choice) act aims at making it easier for the municipalities to introduce a 'customer choice' (voucher) system for publicly financed care services (Meager and Szebehely 2010). At the same time, state incentives to municipalities were introduced to promote the development of voucher systems. These incentives have been taken up by 60 per cent of the Swedish municipalities. Despite these changes, around 85 per cent of tax-financed services continue to be publicly provided in Sweden as a whole. It is often found that the largest income differences in the country are between singles and couples. A national survey, called Senior 2005, showed that among single people aged 65-69, about 20% will have an income under what is considered a reasonable standard of living (according to the national standards for granting financial aid) for a long time into the future (SOU 2003, p. 91). The purpose of the new system was to protect the individual against excessively high costs of municipal care (maximum rate or high cost insurance), and to ensure that all individuals have a minimum sum for living expenses once all fees have been paid known as a reservation sum (Socialstyrelsen 2002). (Nyberg 2010)

Italy

In Italy, use of the cash-for-care allowance, initially set up to provide income-replacement to disabled people unable to work, has grown to 4% of the population in 2004 (between 6 and 22% of the elderly, depending on the region), and is today the main and most significant source of financial support for elderly in need of long-term care.

Appendix G: 2014/15 Funding Lift Comparisons between BC Health Authorities

Health Authority		Medical Service Plan (MSP)	Municipal Pension Plan (MPP)	Canadian Pension Plan (CPP)	non-comp support costs[100]	Utilities[101]	Insurance	Wages[102]	Other[103]	Actual Funding Lift (2014/15)
Interior Health	Funded increase	0%	0%	0%	0%	0%	0%	0%	0%	**0%**
	Actual increase	3.98%	1.4%	2.10%	8.42%	4.00%	1.50%	1.0%	7.18%	-
Vancouver Health[104]	Funded increase	✓	✓	0%	✓	0%	0%	0%	✓	**0.65%**
	Actual increase	3.98%	1.4%	2.10%	8.42%	4.00%	1.50%	2.0%	7.18%	-
Fraser Health	Funded increase	0%	0%	0%	✓	✓	0%	0%	0%	**0.39%**
	Actual increase	3.98%	1.4%	2.10%	8.42%	4.00%	1.83%	1.69%	7.18%	-
Island Health	Funded increase	0%	0%	0%	✓	0%	0%	0%	✓	**1.18%**
	Actual increase	3.98%	1.4%	2.10%	8.42%	4.00%	1.50%	1.75%	7.18%	**-**

Actual Increase: BCCPA surveyed members to determine an estimate of the actual year-over-year cost increases in a number of categories as listed above.

✓ Indicates that the Health Authority funding lift covers this identified cost.

[100] These would include, Medical Supplies, Food & Dietary, Housekeeping & Laundry and Plant Services.
[101] Gas, Electricity, Water
[102] This includes contracted workers
[103] Extended benefits, EI
[104] The funding lift for Vancouver Coastal was taken from the average lift ($.98/bed/day) divided by the average per diem ($150.69) provided to contracted residential care sites in the fiscal year 2014/15.