

# Editorial: Policy Issues in Care for the Elderly in Canada

This special issue of the *Canadian Journal on Aging* focuses on the current discussions about the future financing of health care and social services in Canada. These discussions are of particular relevance to Canadian elders both because the growth in their numbers is often perceived as one of the contributors to the need for change and because they have a major stake in the outcome.

It is, therefore, important to examine whether the current financial, economic, demographic and technological pressures have radically modified the parameters defining the financing, planning and management of health care. Can the current terms of health insurance be maintained? Quebec, for example, set up a parliamentary subcommittee in 1991 to examine a radical reform of the financing of medical services on the assumption that the debt crisis necessitated drastic action. This debate elicited proposals for solutions such as the imposition of user fees, de-insurance and privatization. The proponents of these solutions claimed that these remedies would not only address fiscal constraints but would improve the functioning of the system over the long haul.

The contribution of Robert Evans, Morris Barer and Greg Stoddart in this issue demonstrates, however, that such solutions would result in weakening the capacity of provincial, regional and local governments and organizations to control the cost of health services and to make appropriate health care decisions. These types of responses to our current problems, would, if implemented, have the paradoxical consequences of increasing the cost of medical services and aggravating the problem.

Though the debate on user fees and de-insurance seems to have faded away, the 1995 federal budget with current and built-in future reductions in federal transfer payments to the provinces for health care, education and social services will likely revive the debate. Nevertheless, the focus of the debate on social programs may well now shift from Medicare to old age pensions, while long-term care remains on the agenda. That is why, in this issue of the *Journal*, these three aspects of social policy for the elderly are addressed in ten papers by Canadian authors and in three comments from observers from three countries: France, the United States and Great Britain.

The rhetoric on the financing of medical services ignores an important historical reality. Since the beginning of universal health insurance, the provinces have developed mechanisms which have, until now, shown a capacity to adapt to the new conditions now confronting the health care systems of all western countries. The recent debates have never demonstrated that

this mechanism is fundamentally flawed. The cost of health services in Canada has stabilized and systematic efforts, however modest, have been undertaken to improve the health of the population or correct deficiencies such as meeting the need for long-term services. As a legacy of universal health insurance, we also have the capacity to respond to current problems within the fundamental parameters of universality. Instead of assuming that our current health care system can meet the challenges it faces, it is too easily assumed by some Canadians that the system has to be radically transformed (see Ted Marmor's comment in this issue).

Why then are we still hearing claims that Canadian Medicare has to be transformed? Why is it that the federal government intends to review Old Age Security (OAS) and the Guaranteed Income Supplement (GIS)?

The politics of the debt (see Myles & Street and Walker in this issue) and the alleged demographic time bomb (see Denton & Spencer and Barer et al.), plus technological advances in medical care are always at the forefront of arguments suggesting the near collapse of Medicare and OAS policy in Canada and other countries. Understanding the dynamics of demographic trends in conjunction with medical and long-term care (LTC) services development is the first step in defining parameters for social policy for the elderly, if only to assess the reality of the demographic menace.

The two papers by Frank Denton and Byron Spencer and Morris Barer, Evans and Clyde Hertzman approach this issue from different viewpoints. Denton and Spencer provide estimates of medical and long-term care resource needs for the next 50 years given current demographic, technological and service provision trends. Thus, they are not factoring out service provision and technological change from demographic trends; in this sense, their projection exercise is not wholly demographic. They agree that changes in the health care sector, independent of demographic factors, have altered the allocation of resources in the recent past. Understandably, in their paper, they are not willing to bet on the direction of change in medical technology and service provision over the next 50 years.

Barer et al. investigate recent historical trends in medical care use, hospitalization and long-term care service utilization by the elderly to estimate the respective impact of demographic and service provision factors. Demography explains about 30 per cent of the increase in hospitalization: the elderly increased their share of use of hospital resources in a period when hospital bed availability decreased, while they also increased their use of institutional long-term care services. Thus, demography is not the main contributor to the increased medical care cost. This issue is also examined by Charlyn Black, Noralou Roos, Betty Havens and Leonard MacWilliams for medical ambulatory care with Manitoba data. Their findings are in line with those of Barer et al.: increases in the 65 and over population explain nearly 40 per cent of the growth in the number of physician visits in the 1970 to 1983 period; 33.4 per cent is attributable to increase in service use by well elderly, 10 per cent is attributable to the use by ill elderly persons.

Demographic factors are difficult if not impossible to control. However,

papers by Havens and by François Béland and Anne Lemay examine the possibility of modifying how services are provided to conserve resources. Both their papers, and some of Gérard de Pouvoirville's comments seem to indicate that we can, with prudence, achieve useful results.

Havens describes long-term care components within the context of the continuum of care. Canadian Medicare covers costs for persons with medically certified diagnoses; long-term care is devoted largely to frail elderly with functional incapacities. Their inclusion within the terms of the Medicare principles is examined with an emphasis on universality. Havens' approach is to examine the specificity of LTC services and their clientele and to derive from these first principles a logic for a publicly-financed and mostly publicly-run LTC system.

Béland and Lemay approach the study of LTC policies from another perspective. First they argue for the specificity of LTC in regard to medical care, then they ask whether the provinces' political rhetoric on enhancing community LTC and on the development of a social model has any reality. Data from Quebec show that the total community LTC budget increased in the 1980s while hospital budgets remained stable. In fact, hospital resources were reoriented within the hospital sector from young and middle-aged adults to elderly persons. This trend is similar to the Barer et al. findings in British Columbia. The total LTC budget, however, is still mainly devoted to institutional care.

In common with many Canadian provinces, Ontario examined its LTC policy and proposed, in a number of policy documents, a new orientation with emphasis on a social LTC model: community programs and services, public agencies as main providers of care and help to informal caregivers. These proposals are similar to LTC policy statements in most of the provinces (Béland & Shapiro, 1994). However, in discussing the Ontario reform process, Raisa Deber and Paul Williams note the effect of the manifold consultation processes Ontario used to sort out its LTC policy. These consultations were perceived by many as a way of postponing action to address difficult issues; the process itself also legitimized the contradictory pressures exerted by special interest groups. The Deber and William paper focuses on the political decision-making process, an issue rarely touched upon in the study of LTC. Defining the continuum of care, describing historical trends in LTC development, dealing with myths in elderly use of services are important topics, but their contribution highlights the fact that political processes (sometimes accompanied by heated debate) can, from time to time, produce important changes in direction, implementation and services delivery.

The paper by Carolyn DeCoster, Roos and Evelyn Shapiro focuses on the delivery of long-term care facility services. They note the importance Manitoba and other provinces attach to assessing how well regionalization, access, and management are functioning. They show how a population-based health information system can be used to assess aspects of LTC policy and management in the context of a co-ordinated and regionalized LTC sys-

tem.

The paper by John Myles and Debra Street on the future of old age pensions in Canada shows how the politics of the debt affect the debate on pensions and its possible outcomes. Two solutions (a "conservative" and a "progressive" response) are examined. The 1995 federal budget answered the Myles and Street question: the universal pension is definitely out, deep cuts in unemployment insurance are in, and there is no plan to examine the working career of Canadians from a life course perspective. If the outcome of the new federal social policy is a reduction in total life earnings for an important part of the Canadian population, particularly if it increases income and job insecurity for young and middle-aged adults, lowers the disposable income of the elderly and increases income inequality, not only will pensions have been "clawed" back but also the recent gains in life expectancies (see de Pouvoirville in this issue).

Although the federal government has promised to maintain the principles of the *Canada Health Act*, particularly universal access to health care, cutbacks in transfer payments to the provinces will be felt most severely starting in 1997–1998. Therefore, its ability to maintain and embrace the provisions of the *Canada Health Act* may depend on the provinces' capacity to absorb the cuts within their actual budget base which is already strained. How further restrictions are to be implemented in the health care sector among others without affecting access to and the availability of care is not at all clear. Also, as Evans et al. assert, there are groups with entrenched interest in securing sources of funding other than from general taxation. The debate on user fees and other forms of users' contribution to health care spending is bound to resurface as the full effects of the federal cutbacks on fiscal transfers to the provinces are felt.

Evans et al. argue that user fees cannot play the role claimed by their proponents. Béland uses data to show that Medicare in Quebec has been successful in redistributing the burden of medical care costs between households. The data show that middle-income households and low-income individuals have an objective economic interest in preserving the integrity of Medicare in Canada. Evans et al. assert that there are good reasons for "Zombies" (user fee proponents who continue to reappear like ghosts) to walk in the dark: user fees have redistributive effects and some (the rich and the healthy) would benefit while others (the poor and the sick) would lose. U.S. data also demonstrate that the very rich benefit more from user fees than the middle class. The danger is that middle class people may be persuaded to support the imposition of user fees by not understanding its effect on their own welfare, paving the way for the deterioration of our national health insurance system.

This issue of the *Canadian Journal on Aging* ends with comments from three observers of the Canadian scene from France, the U.S. and Great Britain. We invited these contributions because, as editors, we were convinced that external commentators would not only help us assess our policies and dilemmas from a broader perspective but also help us reflect on the many-

sided perspectives of the papers in this issue. De Pouvoirville and Alan Walker see parallels between the debates in France and Great Britain and those in Canada. Marmor pleads with us not to fall prey to American ideas and myths about national health insurance. Their insights add much to this volume.

De Pouvoirville reflects on the need for more resources in the LTC sector and on our country's ability to reallocate resources from the traditional medical and institutional sectors to invest in community LTC. This shift did not happen in Quebec, as shown by Béland and Lemay, despite over a decade of government rhetoric and promises. De Pouvoirville remarks wisely, using Canadian work on the determinants of health (Evans et al., this issue), that reductions in old age security policy and changes in income distribution could result in future increases in mortality and morbidity rates because of the documented association between income distribution and health. A cynical interpretation of the social policy in the making in Canada would be that the actual and predicted increase in income inequalities will help to reduce the need for pension provisions 50 years from now!

Walker and Marmor, in their respective papers, both emphasize the ideological debates and their possible outcomes. Marmor claims, rightly, that we as Canadians should pay attention to the U.S. debate, not because it can teach us anything useful about what to do, but because it can teach us what not to do. Walker also makes the same point: from Great Britain, Canada should learn where not to head when the starting point is a publicly-financed and publicly-run health care system. Themes familiar in the actual Canadian debate are recognizable from Great Britain's case: the role of the family, participation of clients and citizens, universality of access, the role of the private and public sectors, a needs- as compared to a market-based approach to resource allocation. There is a difference though, at least in the recent policy documents. Participation is defined much less as guaranteed through market devices than through direct participation of the clientele and citizenry in decision-making bodies either at the level of program agencies or regional bodies; access to health care is a value entrenched in the Canadian ethos (Havens in this issue), markets are not emphasized as a way to increase efficiency (Deber and Williams in this issue). Finally, the family is seen as the main provider of care; here policy options are much less defined and there is some fear that governments will devolve responsibility to family, that is, female family members (Rosenthal, 1994).

This special issue is meant to contribute to a multi-faceted debate on the financing of health care services. We hope that the outcome of serious discussion will have a major impact on all Canadians because the major effects of an erosion of the principle of universality will be felt in the symbolic, political and institutional spheres: symbolic to the extent or in the sense that the solidarity of our society will have diminished; political to the extent that decision-making power in relation to medical services will shift from public organizations to private organizations; and organizational to the extent that society's capacity to adapt to the needs for health services and to

technological change will be reduced.

Elderly persons risk being particularly seriously affected by the results of such a policy change because of the extent to which illness in the Western World is concentrated in that subpopulation. The challenge of long-term care has not been fully resolved. Governments, institutions and voluntary organizations are making worthy efforts in this regard but few provinces have implemented the complete gamut of required policies, programs and institutions, even though some provinces have made more progress than others. The challenge governments now face in this regard is certainly financial but it also has ethical, moral, political and institutional dimensions.

We believe that it is to the extent to which governments ascribe to the general principles of universal health insurance and the extent to which they manifest the same dynamism in the planning, implementation and organization of long-term care that we will have long-term care services which are well-organized and financed at an adequate level.

## References

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