

Notes from the Editor-in-Chief

THE CANADIAN HEALTHCARE ASSOCIATION (2009) recently published a policy document that opens with a matter-of-fact but still striking observation: most Canadians expect that publicly funded health services will be available to them whenever and wherever in the country they need them. But here's the rub: it is often not until people require facility-based – aka “residential” – long-term care (LTC) for themselves or a family member that they discover that such care – or, at least, certain significant portions of it – is not necessarily included under the public umbrella. Adding a further layer of complexity is the fact that the types and quality of LTC and access to it diverge widely across the country.

This issue of *Healthcare Papers* strides boldly into the quickly evolving and highly politicized LTC terrain. Setting our course is a lead essay by Irene Jansen, a senior research officer with the Canadian Union of Public Employees (CUPE). Jansen's contribution surveys the state of access to and quality in Canada's LTC sector, and then proposes solutions she believes will improve the state of LTC and its ability to meet residents' needs. Unequal, poor and two-tiered access; long waits and growing demand that is not being met by new beds; uneven care; unreasonably low staffing levels; inadequate working conditions; and growing privatization: these are the main problems that, according to Jansen, afflict Canadian LTC.

More than her anatomization of the ills plaguing the sector, readers of this journal will likely find most interesting Jansen's three recommended policy changes and investments designed to address those access and quality challenges. Adhering closely to a CUPE (2009) research paper, Jansen argues for the following:

- Creation by the federal government of a pan-Canadian LTC program (including residential, home and community care) that incorporates the Canada Health Act's criteria and conditions
- Immediate quality improvement accomplished by increasing staffing and legislating “mandatory” minimum staffing levels; fostering better work environments by, for example, reducing injury rates and improving governance, management and organizational practices; and supporting further education for workers
- The stopping and reversing of privatization in all its forms: financing, ownership, management and delivery; this would entail steps such as granting new beds to non-profit operators, placing a moratorium on reclassifying LTC facilities as “assisted-living” facilities, banning the contracting of work out and using public funds to finance new builds and renovations

This list of, in Jansen's words, “bold actions” catalyzed a great deal of thoughtful commentary from the other contributors to this issue. In deep agreement with much that Jansen has to say and, in a certain sense, an extension of her paper, Karl Samuelson's commentary takes as its starting point that the only way to truly ensure resident-centred care is to engage in a national dialogue on what “quality” means to residents themselves. This entails, Samuelson argues, going beyond stiffer or more extensive regulatory standards, neither of which leads to better experiences for residents. Rather, on his account, residents do not measure quality of care primarily by incidences of pressure ulcers and infections but, rather, by quality of life. We therefore need a deep “culture change” founded on develop-

ing, assessing and acting on quality-of-life outcome indicators, such as being treated with respect, a sense of community and perceived staff competency and empathy. To get to where Samuelson wants the LTC system to evolve requires, in his estimation, replacing the current and long-standing “institutional model of care.” (Kimberlyn McGrail notes in her commentary that Canada spends a far greater proportion of its public dollars on institutional care in comparison with other Organisation for Economic Co-operation and Development [OECD] countries.) Samuelson recommends, instead, a “holistic” model, developed and implemented by each facility. Such a model, he argues at length, must also extend to the quality of the working environment.

Jansen’s discussion primarily focuses on facility-based LTC. While she concurs with Jansen on the need to develop a pan-Canadian approach, Diana Gibson contends that we ought to extend such a plan to the whole of “elder care.” In this regard, we could learn from the examples of other OECD countries, such as Denmark, which takes a “comprehensive” approach that bundles together universally funded nursing, health services, personal care and personal assistance across the continuum of care. Such a “New Deal” for Canadian LTC would be affordable, Gibson says, if the federal government had the courage and foresight to implement progressive tax reform.

Margaret McGregor follows much the same evidentiary avenue as Jansen in her assessment of the apparent connection between for-profit LTC facility ownership and lower-quality care outcomes. While much of the research has admittedly been based on US examples, a number of investigations show the situation in Canada appears to square with those findings. McGregor usefully cautions, however, that there is also a diversity of performance levels *within* non-profit facilities; only further research will

clarify “which non-profit models support the best quality.” Like Samuelson, McGregor rejects the notion that merely adding or improving regulations will boost quality in for-profit homes. Sweden’s LTC sector, after all, has virtually no regulations, yet its facilities seem to be performing well.

What are we trying to achieve in Canada’s LTC sector? That question sparks Kimberlyn McGrail’s multi-dimensional response to Jansen’s paper. Acknowledging that there is “no single ‘right’ objective,” McGrail posits widespread basic agreement on two points: (1) LTC is part of a care continuum and (2) people have a deep desire to remain at home and to be as independent as possible. All policy discussions and decisions, McGrail argues, must be informed by those tenets. In her own formulation of the way forward, McGrail parts company with Jansen on two key issues. First, she is critical of Jansen’s claim that a growing population of older adults equates with a certain need to double or triple Canada’s LTC beds; I would agree with McGrail that such a predictive model is too simplistic. Second, McGrail is concerned that Jansen is too negative toward non-facility LTC housing options. Acknowledging the need for new investment in LTC, McGrail says we ought to develop “community-based supports and services and alternative facility arrangements that will lessen the need for the most intense types of service.”

Near the end of her commentary, McGrail makes the provocative assertion that “first-dollar public coverage” of LTC is not a necessary element of nationwide LTC policies and operations. This thread is picked up in Wendy Armstrong’s contribution. Canada’s “glory days” of “first-dollar coverage of a comprehensive basket of hospital and physicians services” for all are, Armstrong observes, a relic of the past. Offering a history of the unravelling of Canada’s “integrated system of social supports”

since the late 1980s, Armstrong zeroes in on the profound impact of the shift from “equal” to “equitable” access (noted in a prescient 1992 article by Mhatre and Deber). As she draws her commentary to a close, Armstrong valuably asks whether, given our current situation, spending more public funds is the answer. Citing the omnipresent Danes and the “essential” principle of comprehensively identifying and acting on care recipients’ needs and circumstances, Armstrong encourages us to look critically at the “discourses around health” before we make any further changes.

Somewhat unconventionally, we decided to conclude this issue of *HealthcarePapers* with an advocacy piece from a non-partisan organization called Public Interest Alberta (PIA). Based in a province that is undergoing serious policy shifts in health services, we believe that PIA’s contribution sheds valuable local light on the more general issues Jansen and her commentators address. PIA aligns itself with CUPE and other groups in contesting any privatization of LTC. Offering a short history of such privatization efforts in Alberta, the PIA piece comes out strongly in favour of a single-payer system and abandonment of both for-profit LTC and designated assisted living (on the latter, see the description by Alberta Health Services [2010]).

As I reflect on all the points the contributors to this issue made, I am left – as I should be by stimulating articles – wanting *more*. To begin with, I want to know much more about the apparent inevitability of poor quality in for-profit LTC facilities. I appreciate the evidence adduced in Jansen’s paper and several of the commentaries, but it is clear to me that we need further research on factors beyond ownership type. In this regard, I reflect on McGregor’s concluding paragraph, in which she alludes to other elements such as team engagement, practice-improvement programs, inter-facility and academic affiliations, better

integration with acute care and proactive palliative care. These and other factors call out for further research. I should note here, too, that as we planned this issue of *HealthcarePapers*, we asked a number of private LTC providers to add their perspectives; unfortunately, none accepted our invitation.

I am also not entirely convinced by Jansen’s strong advocacy of increased staffing; research on nurse staffing in acute care settings, for instance, has gone far past numbers and ratios to consider the influence on care of factors such as education, experience and competency. Quite a lot remains to be learned about the impact on client care of these and other staff factors in LTC. And, finally, I want to know much more about innovations and results outside of Canada. Many of the contributors to this issue refer to foreign jurisdictions (Denmark is a ubiquitous touchstone); however, a full-scale analysis of selected overseas jurisdictions is both needed and warranted.

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