NO.5

PROTECT.
STRENGTHEN.
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EXPAND MEDICARE:

LONG-TERM CARE AND HOME/ COMMUNITY CARE

Canadians need a national program, with dedicated transfers tied to *Canada Health Act* standards, minimum staffing levels, and more public and non-profit delivery. In the absence of federal standards, continuing care (home/community and residential) is a patchwork of programs. Access is two-tiered, waits are long, and quality is uneven. Continuing care services are poorly funded and regulated, offered in many places by for-profits, and fall outside of Medicare. Privatization at all levels – financing, ownership, management and delivery – worsens access and quality problems.

Continuing care varies across provinces* in the availability of services, level of public funding, eligibility criteria and out-of-pocket costs borne by residents/clients. Most provinces have cut long-term care bed capacity relative to the senior population in the past decade, without sufficiently expanding home and community care or adequately increasing staffing to reflect the higher acuity of the remaining residents.[1] There have been new investments in home and community care, but progress is uneven, and unmet needs are substantial.[2] As a result, care is often rushed and underfunded, with poor working conditions leading to poor quality of care and quality of life for residents/clients.

While Canada's aging population does not represent a "crisis" of sustainability as Medicare critics suggest,[3] it does mean that the demand for continuing care will rise.

Canada currently lags behind much of the developed world. For all meaningful purposes, continuing care is excluded from the *Canada Health Act*, and we have no national strategy. Even at the level of information, the federal system is weak. By contrast, Nordic European countries have long-standing public (comprehensive, universal and tax-financed) continuing care programs. Other countries have introduced major public initiatives in the past decade, most notably the United Kingdom, Germany and Japan.

CUPE calls on the federal government to:

Create a national continuing care program, covering long-term care facilities, home and community care, with dedicated transfers financed from general revenue and tied to *Canada Health Act* standards, plus minimum staffing and phasing out of for-profit delivery.

Government committees and a number of national organizations have recently called for federal action on continuing care.[4] Among the most recent, the Parliamentary Committee on Palliative and Compassionate Care recommended that the federal government "implement a right to home care, long term care and palliative care, for all residents of Canada, equal to the current rights in the *Canada Health Act*."[5]

Canadians need a federal continuing care program,† one that is:

- Funded through general tax revenue. Pooling risk widely is more efficient and equitable than any of the other recently proposed options: social insurance, registered savings plans, medical savings accounts and tax breaks for private insurance.[6]

* In this fact sheet, for brevity, we use "provinces" to mean "provinces and territories."
† Allowing for an asymmetrical agreement with Quebec, the program would otherwise fall under one federal transfer and law.

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- Established through stand-alone legislation, with *Canada Health Act* standards, minimum staffing standards and a program to phase out for-profit delivery.

New federal continuing care legislation should incorporate the criteria and conditions in the *Canada Health Act*, namely: public administration, universality, comprehensiveness, accessibility, portability and no extra billing or user charges.

Safe staffing levels and non-profit ownership are two of the most important determinants of quality of care and must be part of the regulatory framework.

- More non-profit delivery will improve quality and access and reduce costs. A growing body of empirical evidence, including two systematic reviews, has demonstrated that for-profit long-term care facilities are associated with lower quality of care and poorer resident health outcomes.[7] They also bring higher costs and two-tier access. Home care is even more privatized in Canada, with similar results.
- Staffing is the key determinant of quality, and national standards must include a minimum level. Higher-staffed facilities perform better on a range of quality and outcome measures, for example, rates of pressure ulcers, weight loss, nutrition and hydration, restraint use and violations of care standards.[8] U.S. experience shows that staffing and care will only improve with legislation requiring facilities to employ staff at specified levels.[9]

Canadians should have access to medically necessary services free of charge at the point of use, whether the setting is a hospital, LTC facility, home or community agency. Care should be safe and of high quality. To achieve this, the federal government needs to substantially increase funding transfers to the provinces for continuing care and make those transfers conditional on compliance with legislated standards.

No. 5 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**