CMHC FUNDING FOR NURSING HOMES:

POLICY AND PROGRAM ISSUES

A BACKGROUND REPORT

A Report Prepared for the Program Evaluation Division, CMHC.

By

Patricia Streich.

FINAL REPORT
September, 1983.

ACKNOWLEDGEMENTS

Research for this report was made possible by the co-operation of the staff in CMHC National Office, Regional Offices and Local Branch Offices. Special thanks are due to the Program Evaluation Division and the Social Housing Division at National Office, to the Prairie Regional Office and the branch offices in St.John's, Fredericton, Quebec City, Ottawa, Toronto and Vancouver. Without the assistance and patience of the field staff, the information required for this research could not have been obtained.

Provincial agencies responsible for institutional care were extremely helpful in discussing the details of their programs and policies. Considerable assistance was provided by the ministries or departments of social services in Newfoundland, PEI, Nova Scotia and Ontario, and the Ministries of Health in New Brunswick, Ontario and British Columbia.

Valuable background information was provided by Health and Welfare Canada with respect to its policies regarding institutional care funding, especially Mr. Gibson, Dr. Michelson and Ms. Prasada.

The Final Report has benefited from comments provided on an earlier draft from people in the Research, Social Housing and Program Evaluation Divisions of CMHC. However, any errors or omissions are the responsibility of the author. The opinions expressed do not necessarily reflect those of the Corporation.

CONTENTS

INTRODUCTION

The purpose of this report is to examine financing issues associated with funding of nursing homes under Section 56.1 of the National Housing Act (NHA). This review is part of the evaluation of federal social housing policies.

The Federal Government, through the NHA provisions administered by Canada Mortgage and Housing Corporation (CMHC), has become a major contributor to the development and operation of care facilities for the elderly in Canada. Currently, federal involvement takes two forms. First, subsidies are provided through the non-profit housing program (Section 56.1), and, secondly, NHA mortgage insurance is available for unassisted mortgage loans made by private financial institutions. Assistance for nursing home projects is a small part of CMHC's total housing activities. No special provisions are made in the NHA and there are no separate funding allocations for nursing homes. Nevertheless, CMHC funding is the major source of financial assistance for the development of non-for-profit nursing homes, and NHA insurance has enhanced access to capital markets for the nursing home sector as a whole.

Several policy questions have been raised about the current federal role in nursing home funding. Two general areas of concern are, first, the nature and impact of the federal role, and secondly, the overlap of federal and provincial financing in nursing home funding. The extent of federal financial contributions to care facilities has not been well documented. Various forms of contributions are made by Health and Welfare Canada as well as CMHC. Provincial arrangements for care facilities vary considerably. Inter-governmental fiscal transfers may be occuring under current arrangements. The Report examines these questions with a view to clarifying the federal policy position on funding arrangements.

The Report focusses on current federal and provincial financing arrangements for the development and operation of nursing homes in all provinces. In dealing with 56.1 funding, the relevant time period is post 1978. However, recent activity should be viewed in the context of policies under former non-profit housing programs. Also, while the focus is on 'nursing homes' , this category of care facilities is not well-defined, and an attempt is made to consider the range of care facilities being funded, the levels of care provided and provincial financial assistance applied. The Report does not address other important issues related to technical standards or underwriting risk, both of which are subjects of separate reviews.

There are four main sections in the Report. Section 1 examines the problem of defining 'nursing homes' by considering definitions used in statistical and funding sources. Section 2 reviews the use of Section 56.1 since 1978 for care projects for the elderly, how the funds are used, the types of projects and the contribution of 56.1 to the development of care beds. Section 3 summarises provincial policies and arrangements for nursing homes. Section 4 considers some key questions about the use of federal 56.1 assistance. The implications for federal policy are highlighted in the conclusion.

SECTION 1 : WHAT ARE NURSING HOMES ?
A Definitional Dilemma.

Most people feel that they have a general idea of what constitutes a nursing home. A nursing home is viewed as a facility or institution in which a wide range of personal care and regular nursing services are provided for people who are no longer able to live on their own or with family and friends but who do not require intensive medical care such as a hospital might provide. However, residential care facilities for the elderly carry a variety of labels and the label used is often not indicative of the function. The services provided may include accommodation (room and board), supervision, personal care,nursing care, and medical supervision and care. An institution for the elderly may be part of another institution (such as a hospital) or residential complex (such as a self-contained housing project) or be a separate unit. Some institutions may provide only one type of service or care (for example,room and board) while others may deliver two, three or more services in combination and in varying degrees depending on individual needs.

In reviewing the use of 56.1, it is evident that no consistent labels have been used to classify projects assisted. At the outset then, various approaches and definitions were reviewed including: CMHC Design Guidelines, Statistics Canada, Health and Welfare, the Federal/Provincial Advisory Committee on Health Insurance and the categorisation of provincial programs.

Following in-depth field and documentary research for the development of the 1979 CMHC Design Guidelines for Nursing Homes and Hostels with Care, the report concluded that:

> "There is no single concept of a nursing home with care services for the elderly. Each province uses a variety of solutions from group facilities offering three or more levels of care to facilities that are a collection of apartments or bedrooms (in the general category of homes for the aged)." (1)

The Design Guidelines made a broad distinction between nursing homes and hostels. Hostels were defined for CMHC purposes as boarding residences which offer meals but no services,care homes,group homes and halfway houses. (2) Nursing homes were distinguished from hostels in that they provide services beyond room and board, usually including some nursing care. At the other end of the spectrum, the distinction between nursing homes and hospitals was based on length of stay (that is that the stay was long term in nursing homes and short-stay in hospitals) and on the extent of medical services provided, the latter being the key difference.

The above definition seeks to reconcile two elements in the concept of nursing homes, namely, the service and the institutional form. A definition based on institutional form is most appropriate for CMHC when funding for the physical plant or project is being considered. However, the institutional definition is not always useful in terms of the services provided. For example, nursing services may be provided in a wide array of institutional settings. Three provinces (Alberta, Ontario and New Brunswick) have programs for facilities that are called nursing homes. In other provinces, similar services are provided in homes of varying types and descriptions. Given that current CMHC policy is to fund only the shelter component of the facility, the care level classification is significant only to the extent that varying unit capital costs are associated with different types of facilities.

Other federal agencies have used various categories and definitions. Statistics Canada provides data on 'Residential Special Care Facilities' from an annual survey. This definition includes

facilities serving aged persons, the physically and mentally handicapped, emotionally disturbed children,alcohol and drug addiction,delinquents,unwed mothers,transients and others. These data provide an age-sex breakdown of residents and distinguish among four levels of care (no care,personal care, nursing care and intensive nursing/medical care). For persons over age 65, it would seem that two-thirds are located in facilities with no care, that is in room and board or hostel types of arrangements. The bulk of nursing homes would seem to be classified under Type 3 which includes about 30 percent of the residents. (3) An alternative Statistics Canada classification is under the collective dwellings category of the Census. The 1981 Census reported some 153,880 persons over age 65 living in 'nursing,chronic care,old age homes' types of collective dwellings, which represents about 8 percent of the 1981 population over age 65. Neither of these Statistics Canada definitions take account of the varying levels of services within residential facilities which would affect the amounts of government funding assistance available.

Health and Welfare Canada has sought to establish guidelines for funding under two provisions, the Established Program Financing (EPF) and the Canada Assistance Plan (CAP). Block,per capita transfers are made to the provinces under the Extended Health Care Services Program of the EPF Act (1977). The Extended Health Care funding covers Nursing Home Intermediate Care, Adult Residential Care, home care and ambulatory services. "The only condition of payment of the EHCS Program contribution is that the provinces and territories provide the Minister of National Health and Welfare with such information as is reasonably required by Canada for international obligations, for the planning and achieving of national standards and mutually useful exchanges of information between Canada and the provinces in relation to health care.' (4) Since the per capita grant covers all different categories of services there is no obligation to distinguish among levels of care. Data provided to Health and Welfare reflect the breakdowns in provincial programs,some of which relate to standard definitions.

Under the cost-sharing arrangements for residual CAP funding, the Federal Government will cover 50 percent of the cost for a person in need in a Home for Special Care not covered by the per capita block grant (up to a ceiling at the OAS/GIS maximum).(5) Under CAP guidelines, a Home for Special Care (defined as a home for the aged, special care facilities or nursing home) may be a separate unit or part of another institution such as a hospital dedicated to special care. Various types of care are included such as domiciliary and supervised, nursing and personal care, and the care must be provided to people in need or likely to be in need. As of March 1981, Health and Welfare reported that there were 5,438 homes for special care with 222,198 rated beds of which elderly persons would be accommodated in 1,671 homes for the aged and 824 nursing homes with 94,791 and 52,784 rated beds respectively. These homes are owned and operated by provincial and municipal governments, by religious and charitable organisations and by proprietory (private) profit organisations. Thus, Health and Welfare funding through CAP is concerned with questions of individual need, while the EPF funding is related to a broad range of institutional care facilities. In neither case is it necessary then to classify the types of facilities at different levels for funding purposes.

The Canadian Governmental Report on Aging (1982), Canada's report for the World Assembly on Aging, utilised the Homes for Special Care data from Health and Welfare Canada. Exhibit 1 taken from that report shows the distribution of beds in Homes for Aged and Nursing Homes by province. These data represent the most comprehensive information available on a Canada-wide basis.

EXHIBIT I

Rated Beds in Homes for Special Care
(Homes for the Aged and Nursing Homes)
By province and Territory
Related to the population Aged 65 and Over, 1980 *

Provinces	Homes for the Aged	Nursing Homes	Total Beds Related to Those aged 65 +	Rated Beds per 1,000 population 65 +
Newfoundland	1707	30	1737	42.2
PEI	721	547	1268	88.7
Nova Scotia	4817	1558	6375	72.5
New Brunswick	2358	2104	4462	66.9
Quebec	27366	5542	32908	62.2
Ontario	27950	27179	55129	67.8
Manitoba	2822	4006	6828	59.1
Saskatchewan	4824	2412	7236	65.4
Alberta	5429	6797	12226	79.6
BC	13483	3117	16600	61.4
NWT	18	34	52	34.7
Yukon	77	-	77	110.0
Canada	91572	53326	144898	65.7

Sources: Information Systems Directorate, Policy,Planning and Information Branch, Health and Welfare Canada, Statistical Information on Homes for Special Care March 31, 1980, and
Statistics Canada, Population Estimates June 1,1979 (Unpublished).

(This Exhibit is taken from Table 11, The Canadian Governmental Report on Aging, Government of Canada, 1982.)

Various classifications of levels of care have been used in the past. In 1973 a Federal/Provincial Advisory Committee on Health Insurance set down a standardised classification that includes five broad types or levels of care. The detailed description of these is included in Appendix 1. These levels of care classes have come to be used with some common understanding among levels of government and care providers and seem to offer the most useful available means of classifying care provision. The general nature of the levels may be summarised as follows:

Level I :Residential or personal care with minimal nursing care services.

Level II :Intermediate care where regular nursing care is provided daily.

Level III:Extended care where considerable nursing care and medical supervision is required daily.

Level IV :Special Care for people with a stable disability generally with rehabilitative services.

Level V :Acute care for the critically ill.

In addition, a Level 0 was identified as including accommodation in room and board arrangements where no supervision or care is provided.

The question then is how the Levels of Care relate to the facilities where the services are provided. A study conducted for Health and Welfare Canada in 1981, Needs of the Elderly, sought to relate the levels of care services provided to the location where those services are provided in a number of provinces. (6) Summarising the locales or delivery sites identified for the five levels of care in a general way reveals the overlaps which occur in care levels within types of facilities. For example, both Level I and Level II services may be provided in nursing homes, and in some cases Level III services are also available in nursing homes approved for longer term care. Expanding on the classification included in the above report, based on a detailed review of

provincial programs,a summary overview of provincial programs according to levels of care has been developed (Exhibit II).

Generally, most provinces have some separate type of boarding home arrangements which deliver room and board with little or no care. These would equate to Level 0. Above this level, however, there is considerable overlap in levels of care provided within particular provincial programs. Many programs provide for a wide spectrum from personal care to extended nursing care. Furthermore, in some provinces there is overlap among the service providers. Historic distinctions among 'private', government and charitable providers as to services provided,levels of care and clienteles have become blurred. The tendancy is for all providers to offer a wide range of care levels. Such a trend might have been anticipated given the changing needs of a given resident population over time and the difficulties of relocating residents.

From the classification in Exhibit II, nursing homes are defined as those facilities providing Level 2 services,recognising that other levels (I and III) may also be provided in the same program and facility. The provincial programs which fall within such a definition include private (profit) nursing homes, and both public (provincial and municipal) and voluntary/charitable non-profit types. Public,non-for-profit nursing homes or services are provided under programs in four provinces. Voluntary/charitable nursing homes or nursing home services are provided under ten provincial programs in all provinces except Prince Edward Island. The following programs are identified as providing for nursing home services:

EXHIBIT II

CURRENT PROVINCIAL PROGRAMS RELATED TO LEVELS OF CARE (0 to III)

	Level 0 (Boarding)	Level I (Residential/Personal)	Level II (Intermediate/Nursing)	Level III (Extended/Chronic)
NEWFOUNDLAND	Licenced Boarding Homes	------Government Homes for Special Care ----------		Extended care facilitie (Hospitals)
		------Interfaith & Church operated Homes----------		
		------ Provincial institutions ----------		
PRINCE EDWARD ISLAND	Special Boarding Homes	------ Provincial Homes for the Aged (Manors)-----		Chronic Care unit
		Charitable homes		
		------ Private nursing homes ----------		
NOVA SCOTIA (Homes for Special Care Act)				
	Residential Care Facilities	-----Private nursing homes ----------		
		-----Homes for Aged(Municipal and Non-profit)--		Hospitals
NEW BRUNSWICK		----- Nursing Homes (Non-profit)----------		Extended
		----- Private special care homes ----------		Health Care
QUEBEC	La famille d'accueil (Foster family)	Le pavillion ----------	Le centre d'accueil (The reception centre)	Long term care hospitals
ONTARIO	Rest Homes Foster homes	----- Homes for the Aged(Mun. and NP)-----	-- Private Nursing Homes---	Chronic Hospital care
		(Extended Health Care Program applies to % of beds in homes for aged, and up to 100% of beds in nursing homes)		
MANITOBA (Personal Care Homes Program)				
	Manitoba Hostel Care----------		Manitoba Personal Care	Manitoba Extended Care
SASKATCHEWAN (Special Care Homes Program: Levels I-IV)				
	Group Homes ----------			
		----------Special Care Homes ----------		
				Extended care units & Hospitals
ALBERTA	Private Homes for Special Care	Lodge Program	---------Nursing HomeProgram -------	Extended Care centres
BRITISH COLUMBIA	Boarding Homes	Personal Care Homes	Intermediate Care Homes	Extended care hospitals

Sources: Various sources were used including:
- descriptions of provincial programs provided by Health Insurance Division,Health &Welfare.
- program descriptions in the Needs of the Elderly, study conducted by Cluff & Cluff for Health and Welfare Canada.(1981)
- information supplied by CMHC field offices.
- working papers prepared for the Canadian Government Report on Aging (1982)
- telephone contacts with provincial agencies responsible for program operations (Social Services and Health)

Notes: (1) The provincial programs identified above include those under which facilities and funding are currently being provided. However, new facilities may not be being developed under these programs in all cases (e.g. the freeze on Ontario's Homes for the Aged Program).

(2) The ranges of care levels indicated by the broken line is intended to suggest the possible range of care levels that may be provided within these programs. This does not imply that all facilities developed in these programs will include all levels of care.

Province	Government	Voluntary/Charitable
Newfoundland	Government Homes for Special Care	Interfaith & church operated homes
PEI	Provincial Homes for the Aged	
Nova Scotia	Municipal Homes for the Aged	Homes for the Aged
New Bruswick		Nursing Homes
Quebec		Le centre d'accueil
Ontario	Municipal Homes for the Aged	Homes for the Aged Non-profit nursing homes
Manitoba		Personal Care Homes
Saskatchewan		Special Care Homes
Alberta		Nursing Homes
British Columbia		Intermediate Care Homes

Other provincial programs provided for lower levels of care (Levels 0 and 1) with no nursing services. Programs which would not fall within a nursing home definition include provincial boarding homes, Ontario's rest homes,Alberta's lodges and BC's Personal Care Homes.

Thus, while it is possible to relate program provisions to various levels of care, the programs themselves are not defined in these compartmentalised categories. Two important implications stem from this program context. First, it is extremely difficult to relate care levels to the physical facilities. Provincial financial contributions relate to the services provided to given residents rather than to the facility or project itself. Secondly, given that most programs allow for a range of care levels to be provided, establishing project funding guidelines based on a level of care approach would be quite difficult, even for the initial period of operation of a facility. Over time, as the care required changes, provincial funding provisions may be changed and the facilities themselves may undergo reclassification and physical alteration.

There is no question that the regulation,licencing and control of all types of residential care facilities are matters of provincial jurisdiction. Any federal funding vehicles whether through Health and Welfare Canada or through CMHC are bound by the provincial program vehicles, criteria and definitions:

> " All provinces and territories provide institutional care for aged persons. An institution may provide residential care, personal care, or nursing care, or a combination thereof. Both health and welfare services are included and range from minimal to more intensive levels of care." (7)

Federal dollars contributed to care facilities are virtually invisible and federal leverage in the application of those dollars extremely limited. The federal-provincial funding issues are made more complex because of the combination of shelter,health and social welfare services included and the multiple agency financing. For these reasons, the definition of nursing homes is itself a policy issue with federal-provincial relations implications.

SECTION 2 : THE USE OF SECTION 56.1 FUNDING FOR NURSING HOMES

In this section the following aspects of CMHC funding for nursing homes are examined:

1. Legislative provisions
2. CMHC operating guidelnes and procedures
3. Volumes and types of activity
4. Application of 56.1 assistance (shelter v. care)
5. The Federal Funding Context

2.1 NHA Legislative Provisions

The NHA does not now and has not in the past made any special legislative provision for nursing homes or care projects. However, since 1945, the Federal Government through the NHA has participated in capital financing of nearly one-third of all institutional beds for the elderly in Canada.

Early NHA arrangements included direct loans at preferred interest rates. The 1973 NHA Amendements made provision for loans from CMHC plus a 10 percent capital grant for projects undertaken by non-profit sponsors. Pre-1978 activity generally took the form of hostel accommodation with rooms,room and board or limited personal care. Projects were developed and operated by charitable, religious,service or other voluntary agencies --- many of the same groups building non-profit rental units for seniors. No special legislation was provided. Hostels or care projects were developed within the general non-profit program. Both loan capital and capital grants were provided unilaterally by Ottawa. (8) CMHC was responsible for program delivery and administration.

The 1978 NHA Amendments introduced Section 56.1 as a 'single financial subsidy technique' for all social housing provided by public and private sponsors,provinces, private organisations and co-operatives. (9) The Section 56.1 Non-Profit and Co-operative Housing Programs involved several important changes from prior arrangements including:

- o projects are funded by mortgages from private lenders rather than with direct federal loans;
- o federal assistance takes the form of a unilateral federal housing subsidy to replace the mandatory federal-provincial cost-sharing under former public housing programs;
- o the federal subsidy is limited to capital debt retirement of the private mortgage loan rather than the subsidy being tied to operating deficits of projects.

As in the past, the 1978 legislation made no special provision for care facilities. Care projects are included within the category of special purpose projects, all of which are funded under the same arrangements as all non-profit housing projects.

Currently then, seniors' hostel and care facilities are being developed using private mortgages with an annual federal subsidy to reduce the effective rate of interest to 2 percent with no requirement for matching provincial subsidies or cost-sharing. While the NHA does not make any special arrangements for care projects, general NHA non-profit provisions are available for institutional projects. Certainly, care projects are not excluded from eligibility for 56.1 funding under the terms of the Act.

2.2 CMHC Guidelines and Procedures

While no special legislative provisions have been made for care projects, CMHC's operating Manual included special guidelines for the funding of care facilities.

The Manual outlines several key areas where care facilities may be treated differently from other projects including:

- o Capital funding
  Given that some part of care facilities may be provided for care rather than for shelter, eligibility for CMHC funding is conditional on the care component being less than 15 percent of total capital cost and on less than 20 percent of the total floor area being devoted to 'care' uses.

- o Subsidy funding
  The federal subsidy is available to reduce shelter costs only. It cannot be applied to the care costs. The 56.1 subsidy is to be applied against the debt retirement costs of the capital financing for the project. By implication, the federal contribution could not exceed the amortization costs of the project since the amount available may only reduce the effective mortgage interest rate to 2 percent.

- o Funding of the Care component
  Prior to CMHC commitment under Section 56.1, the sponsor is required to obtain assurances of provincial funding for the care component (grants and/or per diem rates). Generally, a project would be ineligible for 56.1 funding if the costs of care could not be covered from provincial sources and resident contributions within established provincial per diem rates.

In most cases, where the maximum 56.1 assistance is required at project initiation, the federal subsidy continues at the maximum rate for the life of the mortgage. This 'guaranteed' rate of federal assistance provides some security to the private lender that the debt will be retired as well as minimizing the risk to the mortgage insurance fund. The policy is based on the assumption that incomes and revenues will remain fairly constant for the client group served while other operating expenses tend to increase.(10)

To assess the operating practices related to these guidelines, a number of CMHC field offices were contacted during the research.(11) These contacts suggest a wide variety of field experiences exist in implementation of the operating guidelines. The variation seems to relate to a number of factors including the complexity of projects undertaken (especially the degree to which mixed use projects have been funded), the extent of

provincial involvement and funding, and so on. Generally, the capital funding guidelines seem to present little difficulty because in most care projects, considerably less than 15 percent of capital costs would be comprised of care-related items. A few provinces cover the capital financing of the care component. Given that most projects fall within the 56.1 guidelines for capital financing, few applications would be rejected on these grounds. Once capital costs have been determined, the 56.1 subsidy is generally applied to the maximum level and remains at that level for the life of the mortgage. Determination of the shelter versus care operating costs have presented some difficulties as have the annual reporting of revenues from sources other than CMHC. The concept of a low end of market rent for a bed in a nursing home seems conceptually and practically difficult to apply. Project funding is usually conditional on the care component being self-supporting (i.e. that the costs of the care be covered by provincial subsidies and residents' contributions to care expenses). Much of the responsibility for annual project budget reviews rests with the responsible provincial agencies after initial CMHC approval and project completion.

2.3 Volumes and Types of Activity

As noted above, hostel and care projects for seniors are included in the general category of 'special purpose projects' funded under 56.1. CMHC Administrative Data does not distinguish among the types of projects funded. From 1978 to 1981 some 11,224 hostel beds were funded. (12) A special tabulation was obtained to seek to identify those projects which provide hostel or care facilities for seniors. Some 136 projects were identified as including beds/care units for senior citizens with 56.1 commitments from 1978 to 1982. (13) Excluding the self-contained units in these 136 projects, a total of 7,874 beds /care units were assisted through 56.1 in the period from 1978 to 1982. This represents close to 70 percent of all 56.1 hostel beds assisted, the balance being accommodation for the disabled,transition houses, group homes for children,homes for battered women and so on.

The distribution of hostel/care facilities for seniors by province (Exhibit III) reveals the concentration of this activity in two provinces, Quebec and British Columbia, each of which account for a third of the total activity. According to these data, Section 56.1 has not been used for seniors projects in Alberta, the one province which has its own programs to finance construction of both hostel-type and nursing home projects. Some provinces have used 56.1 special purpose funding almost exclusively for seniors for example, Quebec, Manitoba and New Brunswick. Relatively small proportions of 56.1 funding has been used for seniors special purpose in Ontario, Nova Scotia and PEI.

The majority of these projects were developed in the years 1979 and 1980. (Exhibit IV) The number of projects funded in 1980 and 1981 was high because of the considerable volume of activity in the Province of Quebec in those years which was related to efforts to commit available funds from the global budget allocations.

EXHIBIT III

Section 56.1 Funding for Seniors Hostel/Care Facilities, By Province, 1978 to 1981.

Province	All 56.1 Hostel Beds	Seniors Hostel/Care Activities							% of all 56.1 hostel beds
		# Projects	Self-contained units	Beds (1)	Care units (2)	Care beds (3)	Total (1-3) No.	%	
Newfoundland	107	2	209	-	-	73	73	1.0	68.2
PEI	171	1	-	67	-	-	67	0.8	39.2
Nova Scotia	516	4	-	32	-	145	177	2.2	34.3
New Brunswick	759	11	-	-	50	505	555	7.0	73.1
Quebec	2366	43	-	80	677	2048	2805	35.6	100
Ontario	1516	11	81	183	151	397	731	9.3	48.2
Manitoba	510	13	-	50	138	237	425	5.4	83.3
Saskatchewan	427	8	-	51	70	107	228	2.9	53.4
Alberta	434	-	-	-	-	-	-	-	-
BC	4418	43	10	439	53	2321	2813	35.8	63.7
CANADA									
Number	11224	136	300	902	1139	5833	7874	100	70.1
Percent				11.4	14.5	74.1	100		

Sources: *Table 4.57, Section 56.1 Non-Profit and Co-operative Housing Program Evaluation, Program Evlautaion Division, CMHC, April 1983.

Special tabulation from 56.1 administrative data files obtained by Program Evaluation Division, CMHC, August 1983.

EXHIBIT IV

Hostel/Care Projects for Seniors by
Year of Commitment under Section 56.1

Province	1978	1979	1980	1981	1982
Newfoundland		1	1		
PEI			1		
Nova Scotia		2	1	1	
New Brunswick		7	4		
Quebec		7	15	19	2
Ontario	1	2	7	1	
Manitoba		4	8		1
Saskatchewan		3	5		
Alberta					
BC	4	18	19	2	
# of projects	5	44	61	23	3

(Source: CMHC Administrative Data, National Office.
The Social Housing Evaluation included only those projects completed and occupied by 1982.)

Administrative data do not permit classifcation of the above projects by levels of care. In an attempted classification, CMHC field offices and some provincial agencies were contacted to determine the character of the projects and identify nursing home projects or those with nursing home services. Classification is made difficult by the combination of levels of care within projects especially in the Atlantic provinces. In these cases, a breakdown of the beds according to the three levels of care was requested. It should be noted that, even though these data are not currently provided on CMHC administrative reports, provincial agencies would have no difficulty in providing the information if it was requested for the 56.1 assisted projects.

In relation to the Levels of Care classes discussed in the previous section, nursing homes would be defined as those providing at least Level II care, or projects which provide Level II care to a substantial portion of the residents (even though some may be receiving Level 1 care). Based on these criteria, Section 56.1 assistance has been used for nursing home construction in all provinces except Alberta.

A distinction can be made between provinces which have used Section 56.1 almost exclusively for nursing home construction, and those where a range of institutional accommodation has been built. In Newfoundland and New Bruswick all projects assisted have been classified as nursing homes. In British Columbia some of the projects funded from 1978 have been for Level 1 care, but currently all new projects are being provided at Level II,nursing home standards (known as Intermediate Care). Provinces which have tended to use Section 56.1 for lower levels of care include Ontario where much of the activity has been for Rest Homes (Level 0) plus one Home for the Aged (Level 1) , and Nova Scotia which describes its facilities as Homes for the Aged and has a policy of moving people into institutional hospital settings as they require higher levels of care.

A second distinction can be made between those provinces which provide a wide range of care levels within the same facilities and those which have differentiated facilities. For example, Newfoundland's Homes for Special Care, PEI's Manors, New Brunswick's Nursing Homes and Saskatchewan's Special Care Homes all provide a range from Level I to III in their facilities. By contrast, provinces such as Ontario have seperate provisions for Levels 0,1, and II to III care levels,although the Extended Care program provides the funding vehicle to finance nursing care in both nursing homes and Homes for the Aged. Similarly, although British Columbia has distinct provisions for Personal Care (level I) and Intermediate Care (Level II), people may receive care at Levels I,II or III in Intermediate Care facilities.

Based on our review of the projects financed with 56.1 assistance, it is estimated that about half the projects identified as seniors hostel or care facilities could be considered as nursing homes under the Level II definition. Since nursing homes tend to be larger projects than homes with limited care, the proportion of beds provided would be somewhat greater, probably in the order of 60 percent of all beds assisted for seniors. This does not imply that all residents in these projects would be receiving a high level of care but rather than the level of service available would equate to nursing home standards. Generally about 40 to 50 percent of the beds in these projects are identified as being used by people requiring Levels II or III care. The balance of the 56.1 assisted projects is divided between boarding home/no care (Level 0) and personal care (Level I) in roughly equal proportions.

The Section 56.1 Program Evaluation Report suggested that about 17 percent of 56.1 commitments (units and beds) since 1978 were hostel beds. Our data suggest that about 70 percent of these have been provided for the elderly (Exhibit III). This implies that approximately 12 percent of the 56.1 budget has been allocated to seniors' care facilities. From the estimates above, it appears that of these seniors projects about 60 percent include nursing home services such that approximately 7 to 8 percent of the 56.1 budget has been allocated to nursing homes since 1978.

In assessing the implications of this volume of activity, three factors should be borne in mind. First, the nature of the federal funding commitment to care facilities is that the maximum 56.1 assistance is provided for the life of the mortgage. Aside from mortgage roll-overs,then, the federal subsidy contribution is relatively 'fixed'. CMHC would seem to be locked into an on-going commitment to retire the debt on these mortgages. Secondly, there is evidence that 56.1 funding is being used for higher levels of care.

In a general way, a trend seems to be emerging toward the provision of facilities with higher levels of care both in relation to use of Section 56.1 funding and as a matter of provincial policy. It should be noted that two nursing home projects have recently been funded in Ontario whereas earlier activity was mainly of the Rest Home type. British Columbia has moved away from Personal Care Homes to provide only Intermediate Care facilities because the need for higher levels of care is developing within lower level facilities. In PEI, 56.1 approval was recently given for a new provincial Home for the Aged, the first to be built in many years. Ontario has had a freeze on the construction of Homes for the Aged for many years (although one project was financed with Section 56.1 assistance) and has placed the emphasis on nursing homes. In this situation, it is to be anticipated that a higher proportion of the demand for Section 56.1 assistance will take the form of nursing home projects than in the past. It should also be noted that the tendancy is to provide a wider range of care levels within facilities built to accommodate a higher level of care. Thus, rather than building a Level I facility, provinces are tending to encourage construction of projects within which both Levels I and II services are provided according to resident needs. It would be difficult (if not impossible) then, to base Section 56.1 funding guidelines on the Level of Care distinction so as to exclude the nursing home category.

The third factor to recognise is the extent to which NHA assistance is becoming the major source of financial aid for provision of care facilities for seniors in most parts of Canada. The NHA has always been a major contributor to provision of hostel accommodation for seniors. From 1946 to 1979, about a third of all beds provided (14) have involved NHA assistance. Until 1979, under the former Section 15.1 Non-Profit Program, the policy was to assist hostel-type projects with little or no care and projects with nursing home licences were specifically excluded. Nevertheless, in some provinces, a large proportion of hostel accommodation was provided with NHA assistance (Exhibit V). For example, NHA assistance was

EXHIBIT V

NHA Contribution to Beds for Seniors
1946-1979

Province	NHA Beds for Elderly *	All beds**	% NHA
Newfoundland	1246	1737	71.1
PEI	272	1226	21.5
Nova Scotia	2204	6375	34.6
New Brunswick	2319	4462	52.0
Quebec	14,824	32,908	45.0
Ontario	5287	55,129	9.6
Maniotba	4493	6828	65.8
Saskatchewan	4171	7236	57.6
Alberta	1718	12,226	14.0
B C	6494	16,600	39.1
CANADA	43,028	144,898	29.7

Sources:
* Canadian Housing Statistics, 1979,
** Exhibit 1, The Canadian Governmental Report on Aging, Table 11,p. 1010
The total for Canada includes 129 beds in the Territories.

Note: Data for NHA Beds for Elderly include activities under loans to entrepreneurs and non-profit corporations (Section 15 and 15.1), co-operative housing (Section 34.18) public housing (Section 43), F-P rental housing projects (Section 40), and loans by approved lenders (Section 6).

involved in 71.7 percent of beds provided from 1946-1979 in Newfoundland, 65.8 percent in Manitoba, 57.6 percent in Saskatchewan and 52 percent in New Brunswick. These provinces have developed a historic dependency on NHA funding for institutional accommodation for their elderly populations. By contrast, Provinces such as Ontario, Alberta and PEI have low proportions of their beds developed through the NHA. Following the introduction of Section 56.1, the nature of NHA assistance for care facilities shifted with nursing home projects becoming eligible for financing, and provinces which may have previously utilised other routes for financing these facilities have come to use the NHA as a major funding device. From 1978 to 1982, approximately 18,000 additional beds have been provided across Canada. The NHA share of this additional capacity constitutes roughly 60 percent. Thus, while in the post-war period the NHA has traditionally been involved in about one-third of these types of accommodations, the last four years has seen increasing NHA involvement. These figures do not include those projects insured under the NHA. From 1978 to 1982 some 2,713 beds have been privately financed with NHA insurance. If we assume that other government financing was involved in approximately 2,000 beds (principally through Alberta's programs), the balance which has been privately financed and constructed without government involvement is less than 2,500 beds from 1978 to 1982.(It may be assumed that much of this private category involves private nursing homes mostly in Ontario).

These data imply a growing dependency on NHA assistance for financing institutional beds in most parts of Canada. If NHA insured beds are included with 56.1 assisted beds, it appears that the NHA has been involved in about 80 percent of the additional capacity created since 1978. While there is the historic precedent for utilizing the NHA for these purposes, some concern may be attached to the trend toward use of the NHA as a virtual sole support for institutional facilities. With the exception of provincially

financed nursing homes in Alberta and privately financed nursing homes in Ontario, it appears that other provinces are now heavily dependent on the Federal Government via the NHA to assist in provision of care facilities. It is not clear that this trend has been widely recognised as an emerging role of Ottawa and the federal agency concerned.

The availability of NHA funding for care facilities generally and for seniors' nursing homes in particular has a number of implications. First, by creating a funding vehicle the Federal Government may have encouraged the expansion of the institutional sector at a more rapid rate than might otherwise have been possible. In some cases, it would appear that nursing homes are being provided to higher levels and standards of care than were being provided previously such as in New Brunswick were all new projects are now being constructed to Level III standards even though the mix of resident care needs suggests that only a portion of occupants require this level of care. Furthermore, the accelerated construction of facilities in some areas may have outstripped the availability of provincial operating subsidies required to ensure maximum utilisation of the facilities provided. For example, there is some evidence of projects constructed in the Province of Quebec remaining vacant after completion despite waiting lists possibly because of lack of provincial funding for the care portions of operating subsidies. Secondly, by providing funding that is available only to 'non-profit' sponsors, the NHA may impact on the traditional mix of service providers in this field. In the past there has been a mix of private, government and voluntary operators of care facilities for the elderly. By encouraging non-profit sponsors and principally the private,non-profit sponsorship, there is the potential to reduce the viability of both private sector involvement and the role of direct government provision of necessary services.

Thus, while the proportion of the 56.1 budget being allocated to seniors' care facilities and nursing homes is relatively small on a Canada-wide basis, approximately 7-8 percent, the financial assistance provided has become a major source of support in most provinces and the sole source of support in several. From a policy viewpoint,then, the Federal Government must consider not only the question of how much of its social housing budget should be allocated to meeting these special housing needs, but also the extent to which a federal financial commitment to funding nursing homes through the National Housing Act is being created by the current policy. The 'share' of the 56.1 being allocated to seniors' care facilities is not inconsistent with the proportion of our elderly population being housed in care facilities, approximately 8 percent in Canada as a whole. However, the extent of NHA involvement in new nursing home developments (approximately 60 percent for 56.1 assistance and 80 percent including NHA insurance) places Ottawa in a position as major financier of new nursing homes.

2.4 The Application of Section 56.1 Assistance: The Shelter versus Care Issue

CMHC policy is clear that 56.1 assistance may only be applied to the shelter costs of projects assisted. This policy applies to both the capital and operating aspects of the projects. Since the annual federal contribution is tied to the debt retirement costs of the mortgages, the critical determinant of how the federal assistance is applied is in the initial designation of eligible capital costs. While some care-related capital items are readily identified (e.g. drug dispensing rooms, nursing stations, therapy equipment), precise floor-area calculations for the care component may be difficult to specify. However, as indicated earlier, CMHC field staff appear to feel that the initial capital cost guidelines are being implemented with some reasonable degree of accuracy.

The calculation of the 56.1 subsidy assistance is very straightforward once the eligible capital costs have been identified. Since the maximum 56.1 assistance is applied in care projects, the subsidy is equivalent to the amount required to reduce the effective rate of interest to 2 percent applied to retire the debt on the shelter capital costs.

While the amount of the subsidy is usually not in question, the way in which the subsidy is applied creates problems as far as assessing the effects of federal assistance. In accounting terms, CMHC's contribution is a source of revenue to meet project operating costs (including amortization expenses). However, in initial calculation to assess project viability, the 56.1 subsidy is treated as a first-in contribution and deducted from amortization expenses. By this method, the net shortfall is regarded as 'total project operating costs' (other amortization expenses, + utilities, heat + care costs)which have to be met from residents' contributions and provincial subsidies or per diems. Project 'viability' is determined by CMHC field offices on the basis of these non-CMHC revenues to meet the operating costs less the 56.1 subsidy.

This approach has the effect of obscuring the total project operating expenses and the contribution of the federal subsidy. Further, since residents' contributions are treated as lump sums undifferentiated between payments for shelter,living and care, it is not evident whether the federal subsidy has any effect on shelter expenses to residents, or represents a net saving to provincial governments in terms of lower provincial subsidies. We shall return to the question of who benefits from the 56.1 subsidy later.

An alternative treatment of the 56.1 subsidy could help to clarify the financial picture of these projects. Specifically, if the 56.1 contribution were treated as a source of revenue rather than as a means of reducing amortization expenses, and if residents' contributions could be allocated between shelter and care amounts,

it would be possible to determine the impact of the 56.1 subsidy. However, such an approach requires that both the expense and revenue sides be disaggregated between shelter and care components. Schedule A below demonstrates the current treatment of 56.1 subsidies as compared with an alternative formatting based on a shelter/care breakdown.

Schedule A:Current Treatment of 56.1 Contribution

Total amortization expenses (all capital costs) _____
Amortization expenses:eligible shelter capital costs _____
Less: Section 56.1 subsidy contribution _____
Net Amortization expenses ..... (1)
Other Operating expenses
Shelter items (utilities, heat etc.) _____ (2)
Care items (salaries, supplies etc.) _____ (3)
TOTAL OPERATING EXPENSES (net federal subsidy)..... (4)
(1+2+3)
Revenues: Residents' contributions _____ (5)
NET OPERATING DEFICIT .....
(4 minus 5)
(The operating decifit may equate to the provincial contribution or include provincial subsidies and other revenues from the project sponsor/operator).

Schedule B: A Shelter/Care Formatting of Operating Statements

Expenses:
- Shelter:
  Amortization expenses(shelter component) _____
  Other shelter expenses (utilities, heat etc.) _____
  Total shelter expenses..... (1)
- Care:
  Amortization expenses (care capital costs) _____
  Salaries _____
  Other (supplies etc.) _____
  Total care expenses..... (2)

TOTAL EXPENSES ..... (1 + 2)

Revenues:
- Shelter:
  CMHC 56.1 subsidy _____
  Residents' contributions _____
  Other _____
- Care:
  Residents' contributions _____
  Provincial contributions _____
  Other _____

TOTAL REVENUES .....

2.5 The Federal Funding Context

So far federal assistance for nursing homes has been treated narrowly as an aspect of NHA activity. In addition to 56.1 subsidy assistance, the Federal Government makes substantial transfers to the provinces to assist in meeting the costs of providing institutional care for the elderly and others in need. Furthermore, Ottawa provides income transfers to elderly persons through the Old Age Security (OAS) and Guaranteed Income Supplement (GIS) which are used to cover the residents' contributions to the cost of institutional living and care. Viewed in this larger context, federal housing subsidies are an integral part of the broader federal policy of assisting provinces and individuals with institutional living arrangements. A large proportion of the dollars expended for seniors' care facilities have their origin in federal budgets even though the regulation and delivery of these facilities are provincial responsibilities.

Until 1977, federal Health and Welfare contributed 50 percent of eligible expenses for the operation of Adult Residential Care and Nursing Home Care (called Homes for Special Care). The federal contribution was based on the amounts billed to Ottawa by the provinces. These arrangements were perceived to share many of the problems of cost-shared instruments such as the uncertainty about the claims on the federal budget each year which created budgetting problems for Health and Welfare, and the fact that provinces had to provide a home before they could obtain the federal 50 cent dollars. These arrangements seemed to provide limited flexibility for provincial governments. Provinces were obliged to provide 'homes' even if this was not the preferred route. A major policy change was initiated in April 1977 shifting federal assistance from 50:50 cost-sharing under the Canada Assistance Plan (CAP), to a per capita,unconditional block transfer to provinces for provision of Extended Health Care Services. Provision was made for retention of residual CAP financing to cost-share expenses for items not

eligible under the block grant. However, a ceiling was placed on the federal cost-sharing available.

Block grants under Section 27 of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act ,1977 (known as EPF financing) are intended to cover a range of Extended Health Care Services including nursing home intermediate care,adult residential care,home care (health aspects) and ambulatory care services. According to Health and Welfare officials, the greatest part of the financing is utilised for nursing home and adult residential care services. Initially, the amounts made available to provinces were calculated by distributing the CAP expenditures according to provincial populations. The 1977 flat rate was set at $20.00 per capita; this amount has been escalated each year to $36.07 in 1983-4. Monies are transferred each month to provincial treasuries and becomes part of provincial general revenue funds. In this manner, provincial governments have considerable discretion in the use of the funds as compared with the CAP financing which was made as a federal transfer to a particular line department's budget. In FY '82/3 Ottawa transferred some $815,478,000 to the provinces under the EPF arrangements for extended health care services. Projected expenditures for FY '83-4 are $896 million.

In addition to the EPF contributions, residual CAP funding is available for persons with special needs who may not be receiving the OAS/GIS. The Federal Government will cost-share expenses up to 50 percent of OAS/GIS maximum ($514.35 per month in July 1983). Effectively this approach places a ceiling on CAP funding for eligible individuals and expenses. In fiscal '81-82, the federal contribution under residual CAP funding amounted to $116.7 million. The amounts contributed through CAP vary each year depending on provincial claims. The distribution of EPF and CAP funding provided by Health and Welfare to each province is shown in Exhibit VI.

EXHIBIT VI

Federal Expenditures for Extended Health Care Services, By Province 1981/2 *

Province	EPF Mill. $	CAP Mill. $	Total Mill. $
Newfoundland	16.861	5.7	22.56
PEI	3.639	2.4	6.04
Nova Scotia	25.170	3.3	28.47
New Brunswick	20.684	4.6	25.28
Quebec	191.228	20.4	211.63
Ontario	256.176	35.9	292.08
Manitoba	30.481	3.1	33.58
Saskatchewan	28.760	13.0	41.58
Alberta	66.463	14.4	80.86
British Columbia	81.514	13.7	95.21
NWT	1.359	0.2	1.56
Yukon	688	n/a	.69
CANADA	723.023	116.7	839.72

* Funding provided by Health and Welfare Canada.

Sources: Data supplied from the Health Insurance Division and the Finance Division of CAP, Health and Welfare Canada.

Both the EPF and CAP funding is utilised for all client groups including the elderly, and no breakdowns are available of the proportion of the funds allocated to services for seniors. However, a substantial proportion of the funds are utilised for seniors' care facilities.The EPF and residual CAP funds are intended to cover care facilities in the Levels I and II care categories. Level III facilities are treated as hospitals and funded through federal contributions to health care programs. Level 0 facilities such as boarding homes may be assisted through needs-based payments for individuals through General Welfare Assistance.

The federal contributions to support care facilities (Levels I and II) are made to the provinces concerned. No direct payments are made to the institutions. There are no provisions in EPF or CAP for funding capital costs. While there are no restrictions on how provinces use EPF funding, provinces will tend to utilise them for operating expenses rather than capital items. Even if a province were to choose to use the monies to finance the capital costs of projects, the operating deficits would still have to be covered from provincial sources. Since salaries are the major expense item in operating costs, it would hardly be in a province's best interest to expend these dollars for capital expenditures.

It is important to recognise,therefore, that where 'provincial contributions' are identified in Section 56.1 nursing home projects, some portion of these dollars are provided through Health and Welfare transfers. In the case of 56.1 boarding home type of projects, the federal government is likely cost-sharing on a 50:50 basis in subsidies for persons in need through general welfare arrangements. However, the form of the Health and Welfare financial contribution is quite different from the NHA funding assistance. NHA assistance is project specific and federal contributions take the form of payments related to actual project expenses. Health and Welfare funding is clearly more 'global' than NHA funding in this respect.

Where Health and Welfare does make direct payments these are to individuals rather than to care institutions, via OAS/GIS or or welfare income transfers. As will be shown in the next section, residents' contributions in care facilities are based on the OAS/GIS income amounts. Indirectly,then, the Federal Government contributes an additional amount to the operating expenses of care facilities through its income support programs. Some provinces provide additional income supplements to OAS/GIS recipients, a portion of which may also be utilised to cover the costs of care facilities.

Compared with Health and Welfare (EPF,CAP and OAS/GIS) contributions, the federal Section 56.1 assistance for care facilities is relatively small (in the order of $20. million as compared with $8-900, million per year). However, the two sources of funding are in a sense inter-dependent. Were it not for the NHA capital funding assistance, care projects would not be built in many provinces, and if operating assistance funding were not provided via Health and Welfare , provinces might be unable to finance the costs of services at current levels. There is, however, one major difference namely that levels of assistance through Health and Welfare have been effectively 'capped' whereas CMHC subsidy contributions depend on mortgage interest rates and the volumes of new construction activity generated. While the former is an area where some federal policy jurisdiction pertains, the latter is largely dependent on provincial policy directions under current circumstances.

SECTION 3 : PROVINCIAL PROVISIONS FOR NURSING HOMES

The diversity of provincial programs, funding arrangements, and policies for nursing homes make any generalisations quite hazardous. Rather than attempt a summary of various provincial programs, detailed descriptions are included in Appendix II for reference purposes.

In the context of examining the interface between provincial provisions and NHA assistance, four key aspects of existing arrangements seem particularly relevant,namely:

1. Provincial delivery vehicles: the distinction between health and social service program mechanisms;
2. Levels of Care Provided: the extent of mixed levels and policies toward future development;
3. Pricing policies: the calculation of residents' contributions and provincial contributions;
4. Role of Government: the perception or attitude toward government's role as funding source and service provider.

3.1 Provincial Delivery Vehicles

Provincial programs for delivery of nursing home services fall into two broad types:

(i) Social Service Programs delivered by provincial departments of social services in:
Newfoundland, PEI, Nova Scotia, Quebec, Saskatchewan and Ontario.

(ii) Health Service Programs delivered by provincial ministries of health in:
New Brunswick, British Columbia, Alberta, Manitoba and Ontario.

In the case of social service programs, the cost of service is not treated as an insured health benefit as is the case in the health service programs. In the former case, provincial contributions to cover costs tend to be determined by operating deficits on a project by project basis through annual budget reviews. The residents' contributions are related to the OAS/GIS income less a 'comfort' allowance, however, the resident may pay up to the full cost of the service if his/her income permits. In other words, residents are income or needs tested and the province's contribution determined as a residual. In the case of health service types of programs, the costs of service are covered as an insured health benefit under (15) provincial health insurance. The provinces establish standard per diem rates for each type of accommodation (that is for ward or private room) independently of the actual project costs. The amount of the provincial contribution is fixed for all clients as an insured benefit. The residents' contribution is regarded as a co-payment charge, the amount being established in relation to the OAS/GIS level, that is at a minimum rate. People with higher incomes pay the same amount and receive the same provincial benefit for their care costs. Persons unable to afford the minimum co-charge may apply for additional assistance under general welfare provisions.

Health service type programs tend to provide higher levels of care that is to Levels III and even IV in some cases, and tend to concentrate on the particular level of care whereas social service programs tend to provide a wide spectrum of care levels within one program and within projects. Social service programs are less apt to provide a high level of care and may seek to maintain a distinction between their services and those of a 'hospital' setting.

The use of different routes to provide similar services to similar clients relates to the histories of provincial activities in this field, and the current differentiation is indicative of the stages of development reached among provinces and their health care systems.

Since the mid-seventies at least, the trend has been to bolster the health service provision of service and to reduce the role of social service agencies. Where responsibilities have been divided between provincial health and social service branches, the tendancy has been to amalgamate responsibilites within provincial ministries of health. (16) The extent to which this trend may have been facilitated by the shift from federal cost-sharing under CAP to an unconditional block grant under EPF (where monies are not designated for the use of social service departments) may be an interesting question.

In any event, CMHC in providing NHA assistance for nursing home developments is required to interact with health agencies in four provinces (excluding Alberta which provides its own financing), and social service agencies in six provinces. In those provinces where responsibility has been assumed by health ministries, CMHC appears to rely heavily on the provincial health agencies to scrutinize funding proposals and project operating budgets. In provinces where social service agencies are most actively involved, the lines of authority and responsibility as between CMHC and the provincial agency seem less distinct in most cases. (17)

Thus, CMHC is dealing not only with ten different sets of provincial programs but also with qualitatively different treatments of provincial activity and funding by health and social service agencies. It should perhaps be clarified that the federal EPF financing is available for Levels I and II care irregardless of the delivery through health or social service routes. However, contributions for Level III care are provided through health insurance contributions rather than through the Extended Health Care Program.

3.2 Levels of Care Provided

Except for those non-profit projects where no additional provincial assistance is required (for example Rest Homes in Ontario), control of the levels of care funded rests with the provinces. Since CMHC requires that proposed projects secure provincial approval of funding for the care component before CMHC commitment, care level considerations are currently based on provincial policies. Thus, CMHC has been in the position of responding to applications for 56.1 assistance that are eligible for provincial contributions. Any changes in provincial policies as to the types of care 'required' become reflected in the actual projects funded such as in BC's shift away from Personal Care Homes to Intermediate Care Homes.

CMHC has had little involvement in monitoring the levels of care provided in projects assisted. Contacts with provincial agency staff were required to establish the types of care delivered. Even then occasional conflicting views prevail as to the precise care levelsprovided as a matter of policy versus actual experience. Most provinces acknowledge the fact that care levels are mixed in programs and projects that deliver nursing services. Some selected examples of the mixes including the following:

Province	Program	% Beds/Residents		
		Level I	Level II	Level III
Newfoundland	Homes for Special Care	23	20	58
PEI	Provincial Homes for Aged	23	57	20
New Brunswick	Nursing Homes	10	20	70
Saskatchewan	Special Care Homes	11	23	51
British Columbia	Intermediate Care Homes	50	25	25

Some provinces have policies of providing only Levels I and II care in their programs and would require people to utilize hospitals for Level III care. For example, Nova Scotia and Quebec have policies that would exclude persons requiring Level III from admission. However, as persons age and require more care, it is not always possible to relocate them to hospitals. In Ontario's Homes for the Aged Program

up to 80 percent of the beds may be eligible for Extended Care benefits (the insured levels under OHIP) and in the project assisted by the NHA about 50 percent of the beds were delivering nursing care services at Level II.

The provinces have experienced the problems of aging populations requiring increasing levels of care in existing,lower care level facilities. The need for more care has lead to upgrading of older facilities in some cases to meet the needs. These experiences seem to have contributed to current provincial policies to build for higher level of care initially even though current residents may not require high care levels. Some provinces have experienced declining demand for the low level facilities (for example in BC's Personal Care Homes) leading to a policy change to fund only facilities that may provide the range of care needed.

Even though CMHC has no alternative but to respond to the provincial policies at any point in time, it would certainly be useful to ascertain more clearly the types of care being provided in projects assisted through the NHA. Currently, the difficulty of determining the precise care categories in projects assisted impede a clarification of CMHC policies on care levels the Corporation may be willing to fund. Certainly one alternative CMHC response would be to decline involvement in projects with a large component of Level III care while recognising that provincial policies may be valid given local needs,demands and supply of facilities.

3.3 Pricing Policies

The cost of providing care accommodation are met by two main sources of revenue, contributions from residents and contributions from provincial funding agencies. In 56.1 assisted projects, the federal subsidy is a third source of revenue to cover one category of expenses (namely amortization expenses). In some cases, sponsor contributions constitute a fourth source of revenue where other sources are insufficient to cover expenses. Charitable or voluntary sponsors may cover some expenses through fund-raising or their own resources.

It is probably reasonable to argue that no Canadian senior citizen would be denied access to accommodation with the level of care they require because of inadequate income (providing that the accommodation is available). Where resident incomes are insufficient to cover the required resident co-payment or charge (for example where eligibility for the OAS may be difficult to establish) individuals may usually apply for additional financial assistance under needs-tested,general welfare assistance administered by provincial social service agencies,usually cost-shared 50: 50 with Ottawa under CAP and in some cases including a municipal cost-sharing provision.

(i) Residents' Contributions, co-payments or charges

The principles underlying calculation of residents' contributions differ between the social service and health insured programs. However, the standard resident contribution level is fairly consistent across all programs since it is based on the OAS/GIS minimum income level. Variations in the amounts payable by residents derive from the amount of their incomes that residents are permitted to retain for their personal use, the 'comfort' allowances. Exhibit VII summarises the typical formulae and resident contribution levels under provincial programs for nursing care type services. In some provinces, the level of resident contribution is uniform for all levels of care from Level I through III.

The calculation of residents' contributions are universally income-related. However, in programs funded as insured health benefits, the principle of universality applied implies that all residents pay the standard amount whatever their income level, for example in Ontario, Manitoba, Alberta and British Columbia. Under social service funded arrangements, residents are assessed on the ability to pay principle (that is, income -testing is applied) such that residents contribute up to full cost if their income permits. In effect, then, in social service programs, residents are assessed at a 75 to 80 percent tax rate on the first $514. per month income (the current OAS/GIS rate) and at a 100 percent marginal tax rate on additional income up to full cost or their total income. In both health and service programs, provisions exist for additional assistance for residents on a needs-tested basis through seperate general welfare assistance programs.

EXHIBIT VII

Resident Contribution Formulae & Charges

Province	Formulae	Standard Resident Per diem charges
Newfoundland	Income - $65	$13.50
PEI	OAS/GIS - $50	14.00
Nova Scotia	OAS/GIS - $20-60	14.00
New Brunswick	OAS/GIS - 70	13.50
Quebec	n/a	n/a
Ontario	OAS/GIS - 96	15.19 *
Manitoba	.75 OAS/GIS	12.70 *
Saskatchewan	n/a	13.75
Alberta	.60 OAS/GIS	8.00 *
British Columbia	.75x OAS/GIS	11.50 *

Sources: Provincial program descriptions provided by Health and Welfare Canada and contacts with provincial funding agencies.

Notes

* Health insured benefits apply in these cases.

(1) Resident contributions may vary according to the type of accommodation occupied. E.G. the rate quoted above for Ontario applies to the standard ward rate and residents must cover the costs of private or semi-private accommodation.

(2) Resident contributions may vary according to the level of care received in some cases where distinct program funding mechanisms exist as in Ontario. For example, residents in Ontario's Homes for the Aged may be covered under the Extended Care Program (an insured benefit) and pay $15.19 for a ward bed, or be receiving Level I care not covered by health insurance and paying according to income up to full cost.

(3) Rates quoted above are for most recent dates information is available. Most relate to spring 1983, but some are rates from 1982.

(4) The comfort allowance retained by residents varies by municipality in Nova Scotia where rates are set by municipality. Municipalities cost-share in operating deficits.

(ii) Provincial Contributions

Approaches to determining provincial contributions fall into two groups:

A. Derived from the residual operating deficit on a project by project basis by annual budget reviews. Generally there are no standard provincial 'per diem' rates and each project is assisted up to the actual break-even cost. These are usually associated with social service type programs for example in Newfoundland, PEI, Nova Scotia and in New Brunswick's Nursing Home Program.

Total Break-Even Cost	-	Resident Contributions	=	Provincial Contribution

B. Derived from standard per diem rates uniformly applied in all projects. Projects would have to operate within the maximum per diem amounts, although special cases might be considered eligible for additional funding to cover extraordinary expenses.

Required Resident Copayment	+	Provincial per diem contribution	=	Total revenues (Maximum per diems)

The use of standard provincial per diems for operating costs effectively places a ceiling on the provincial contribution from health insured programs.

Under social service type programs, the provincial contribution is generally regarded as a subsidy to assist individual residents to cover the cost of their accommodation and care, rather than a subsidy to institutional operation. This is consistent with the basic principles underlying the needs-based funding for social services in Canada. Similarly, the health insured approach implies that provincial co-payment of per diem rates is an individual person's entitlement under the rubric of health insurance. Thus, provincial contributions to institutional living arrangements in both cases relate assistance to the individual needs rather than to subsidising the institutions providing the service. This service to people theme also underlies the federal Health and Welfare provisions even though transfers are made to provinces in the first instance. (See Exhibit VIII for provincial costs and average per diem amounts).

EXHIBIT VIII

Provincial Contributions & Project Costs

Province	Average per diem cost or ceiling	Provincial per diem Contribution
Newfoundland	none	Operating deficit
PEI	$57.00	$34
Nova Scotia	45.32	31.32 [1]
New Brunswick	$55.00	$41.50
Quebec	n/a	n/a
Ontario	$42.35	$27.16
Manitoba	$45.00	$32.45
Saskatchewan	none	none
Alberta	$38.00	$30.00 [2]
British Columbia	38.00 [3]	26.50 [3]

Sources: Provincial Program Descriptions provided by Health and Welfare Canada and contacts with provincial funding agencies.

Notes

(1) Municipalities contribute one-third of the operating deficit and bill the province for the remainder. The amount shown here is the total provincial and municipal contribution.

(2) Most of the rates are for 1983, Alberta's rates for 1982. The amounts are the averages of all assistance.

(3) These figures were estimated from the total expenditures less resident contributions divided by number of beds.

Since resident payments are determined through provincial policies, and since the amounts contributed may vary according to the characteristics of the residents, CMHC has no input into setting the resident contributions. Indeed, it would appear that very limited information is available to CMHC on the actual contributions of residents except as a total project revenue source. In many cases, the amount of the resident contribution is not compiled seperately from the provincial contributions -- resident and provincial contributions are reported as a lump sum equivalent to the maximum per unit per diem amounts approved by the provinces. In these circumstances, it is virtually impossible to determine the amount of the provincial subsidy applied in the projects without direct contacts with project sponsors themselves.

A second difficulty arises in trying to assess the extent to which resident contributions apply to shelter-related expenses versus care expenses. Resident contributions are generally not ear-marked between shelter and care. While it may appear that provincial subsidies or contributions are largely destined to cover the care costs and more particularly to cover the salary expenses for care which are the major item of expense, the application of provincial contributions among expense categories has generally not be defined as a matter of provincial policy. Given these conditions, the treatment of resident plus provincial contributions as a lump sum to cover total operating costs (net of the 56.1 subsidy) becomes the description of existing provincial funding practices.

3.4 Role of Governments

While all provinces provide for contributions to the operation of institutional care facilities for the elderly, and all provinces licence and regulate institutions providing care, the nature of provincial involvement varies among the provinces. Provincial policies and programs themselves reflect some of the philosophical differences toward the role of governments in this sector. Several aspects of these policy positions have implications for how the Section 56.1 assistance is being utilised among the provinces. Four particular aspects deserve mention:

(i) Direct provincial government involvement in ownership and management of care facilities;

(ii) Direct provincial capital provisions for development of care facilities;

(iii) Involvement of provincial agencies in the development of care facilities; and,

(iv) Strong traditions of municipal government participation in care provision,especially at lower levels of care.

(i) Provincial Care facilities

A few provinces have established programs for provincially owned and operated care facilities including:

- o Newfoundland's Government Homes for Special Care
- o PEI's Provincial Homes for the Aged (Manors)

However, in most cases, even though the provincial governments may be actively involved in the development of facilities, the operation and management is transferred to a licensed operating group, generally a non-profit community or charitable group. Provincial governments have established their role as regulators rather than as direct service providers although the distinction between care facilities and provincially run hospitals becomes less clear at the high end of the care spectrum,despite separate legislation ,budgets and regulations.

For the most part,therefore, non-profit projects sponsored under Section 56.1 would not relate to provincial non-profit activities, but rather to private or municipal non-profits.

(ii) Provincial Capital Provisions

Relatively few provinces make direct capital provisions for the construction of care facilities. The Province of Alberta is exceptional in its capital financing programs for both nursing homes and 'lodges'. The Province of Ontario has provisions for capital grants of up to $5,000 per bed for Homes for the Aged through the Ministry of Community and Social Services, however, there has been a moritorium on construction of new homes since the mid-seventies. Only replacement of older homes is currently considered for provincial funding, and in one such project assisted through Section 56.1 the Comsoc capital grant was provided at the rate of $10,000 per bed. The Provinces of Manitoba and Saskatchewan both provide the capital for the care portion of projects developed under Section 56.1 in the order of 1/3 and 20 percent of total capital costs respectively.

In other provinces, provincial capital contribution are generally limited to funding minor upgradings of existing facilities (e.g. in British Columbia).

In general then, with the exception of Alberta, provinces have not made provisions for financing the capital development of care facilities. The provincial policy in most cases is to depend on the availability of federal 56.1 assistance or on privately funded development with NHA insurance. Provinces appear to be depending on the NHA funding as a means of implementing provincial policies with respect to care provision.

(iii) Provincial Involvement in Development

Even though provinces may not themselves make capital contributions, the responsible agencies are usually actively involved in the development of facilities. This is to be expected given that standards and criteria are defined in provincial programs. Since in most cases projects are to be operated through private non-profit sponsors, provincial departments have to work with the respective groups to ensure effective management. The Provincial Department of Health in New Brunswick, for example, has a consultant engaged to work with non-profit groups that develop and manage nursing home projects.

The most unusual forms of provincial development involvement pertain in the Provinces of Alberta and Quebec. In both cases, the provincial housing agencies are actively involved. In Alberta the Nursing Home Financing Program is operated through the Alberta Home Mortgage Corporation, and the Lodge Program is operated through the Alberta Housing Corporation. In Quebec, most of the 56.1 activity has been undertaken from the global allocation via Quebec Housing Corporation. However, a special administrative agency within the Ministry of Social Affairs, the Corporation d'Hebergement du Quebec is responsible for planning and development of projects.

In other provinces, the provincial ministries of housing tend not to be involved in the development of care facilities whether by deliberate policy as in Ontario or because responsibility has been assumed within the health or social service departments.

Non-profit projects developed for care may then take on somewhat different characteristics from the typical private non-profit housing project. Although CMHC may be responsible for delivery of the program provisions, a significant amount of the project control rests with the responsible provincial health or social service agencies.

CMHC field staff may be expected to have had much less experience in working with these agencies than with other housing agencies. Also, given the requirement for prior provincial approval of any application, it would seem that the role for CMHC program delivery staff is quite restricted as compared with other non-profit project delivery. Perhaps for these reasons, many of the program delivery functions that would normally be undertaken by CMHC offices may be assumed by the provincial agencies concerned. Such is certainly not the case in all provinces, and in several cases very close working relationships appear to have been established between CMHC and the provincial program staffs.

(iv) Municipal Participation

In the past, municipalities were very much involved in the provision and financing of care facilities for the elderly as well as other needy groups. Nova Scotia and Ontario still depend heavily on municipal Homes for the Aged to meet the needs for Level I care particularly. Alberta's Lodge Program requires that municipal foundations undertake the management of Lodges. In Nova Scotia, municipalities are required to make a one-third contribution to cover operating costs.

Municipalities have tended to be involved at the low-end of the care spectrum, Levels 0 and 1, whereas provincial governments have tended to be involved in nursing care levels II and III. With a declining emphasis on the provision of lower care level facilities, and the tendancy to incorporate a wider range of care levels within projects built to meet higher service needs, the role of municipalities in care provision is declining. Municipal non-profit sponsorship might be considered as an alternative to private non-profit sponsorship for care projects assisted under 56.1.

In most provinces therefore, provincial governments are extremely active in the development of care facilities even though their capital contribution may be minimal and the operation of the facility is under the auspices of a private non-profit sponsor.The care field is highly regulated in a number of provinces if not most. Given these circumstances, the role and relationships of CMHC field delivery operations are somewhat unclear. De facto 'disentanglement' seems to be occuring in various forms depending on local circumstances. The desires of provincial agencies to utilize 56.1 funding (indeed the dependency on this source in some provinces) may account for the seeming ease of collaboration and co-operation surrounding the delivery of 56.1 care projects. Certainly a high degree of mutual respect appears to exist between local CMHC office and provincial agency staffs.

Generally, the provincial roles have been defined as regulators and facilitators of development rather than as service providers or financiers of projects (with some exceptions noted above). Municipal roles have been defined as more direct service providers in some provinces. The federal role has been defined as financier of capital costs through the NHA and of operating expenses under Health and Welfare (EPF, CAP, OAS/GIS incomes and contributions to health insurance programs). While service delivery is being managed and controlled through provincial agencies, on-site operation is provided through types of non-profit sponsor groups (charitable, voluntary and municipal-based). The NHA has been utilised since 1978 not only as a means of facilitating access to capital markets via provision of mortgage insurance, but also to subsidise the capital costs of new construction.

SECTION 4 : POLICY AND PROGRAM ISSUES IN CMHC FUNDING FOR NURSING HOMES

A number of findings of the analysis are worth summarising at this point:

- o DEFINITION OF NURSING HOMES IS A POLICY QUESTION AND F/P ISSUE RATHER THAN A TECHNICAL MATTER :
  - all agencies and levels of governments have difficulties in identifying and classifying care facilities;
  - the F/P Committee definitions of Levels of Care (0 to IV) are the only common basis for classification;
  - services rather than projects are the basis for classification used by federal Health and Welfare and provincial governments;
  - for CMHC purposes, a nursing home was defined as ~~a~~ facilit~~ies~~ in which services to Level II care are provided to at least some portion of residents;
  - provincial programs tend to provide for a range of levels of care within programs and projects.

- o NHA SECTION 56.1 ASSISTANCE IS BEING USED TO PROVIDE NURSING HOME SERVICES IN MOST PROVINCES:
  - no special provisions are made in the NHA for nursing home funding neither is it excluded;
  - CMHC program guidelines make special provisions for care facilities as regards eligible capital and operating costs for federal assistance. The guidelines seem to be applied with some consistency but considerable difficulty;
  - it is estimated that approximately 7-8% of the 56.1 allocations since 1978 have been made for nursing homes plus an additional 5% for seniors care facilities at lower levels of care;

- although a small part of the 56.1 allocations are being used for care facilities for seniors, the NHA assisted developments have been a major source of capital financing for the additional bed capacity created since 1978. An estimated 60% of additional beds provided have been with federal 56.1 assistance plus a further 20% have been under NHA insured mortgages. The NHA is a major support for new development.

- The NHA is only one vehicle of federal support for nursing homes, others being Health and Welfare funding via the EPF, CAP and OAS/GIS. None of these provide for capital financing,however.

o PROVINCIAL PROGRAMS INCLUDE A MIX OF HEALTH AND SOCIAL SERVICE PROVISIONS ALTHOUGH THE BASIC CHARGES TO RESIDENTS ARE INCOME--RELATED IN BOTH:

- basic resident contributions are defined in relation to the federal OAS/GIS income levels;

- Health programs provide for universality while social service programs depend on income-testing and the ability-to-pay principle. Additional needs-tested assistance is available if required;

- resident contributions are not ear-marked between shelter and care portions, and frequently the resident/provincial contributions are not distinguished in 56.1 project statements;

- the provincial governments' roles have been defined as regulators rather than service providers or financiers in most instances.

Quite clearly, NHA funding is being used to assist the development and operation of nursing homes in many parts of Canada. The Section 56.1 federal non-profit assistance is also used for hostel and limited care facilities for the elderly and other special need groups. Whereas NHA participation in special hostel arrangements has a history rooted in federal housing legislation and practice as far back as 1946, the assistance of nursing homes is a relatively new phenomenon that has developed since the introduction of the 56.1 Program in 1978.

Specific concern has been expressed about the use of 56.1 funding for nursing homes for a variety of reasons. For purposes of this discussion the issues are posed in terms of four broad questions:

1. Is it appropriate to use the NHA 56.1 funding to subsidise nursing homes and what are the policy options ?
2. Why is it necessary to utilize housing subsidies for nursing home development ?
3. What are the benefits of 56.1 assistance and on whom are these benefits conferred ?
4. Under current practices, is there adequate federal control and accountability for the funds dispensed under 56.1 for nursing homes?

4.1 The Appropriateness of NHA Funding for Nursing Homes

The pros and cons of funding nursing homes through the NHA have been used to support the case for continuing funding and alternatively for arguments favouring modification of current policies. It is difficult to develop a conclusive argument on either side of this issue since most of the counter-arguments presented will be equally as valid.

The rationale for using Section 56.1 funding for nursing homes include the following points:

- the proportion of total,national 56.1 budgets and activity devoted to nursing homes is relatively minor, certainly less than 10 percent since 1978;
- the funding is valid in meeting special needs of seniors as they age and providing shelter alternatives is a legitimate part of CMHC's mandate;
- the 56.1 subsidies are only applied to the shelter costs not to care costs which are covered by resident and provincial contributions;
- there are few or no alternatives in many provinces for capital funding of nursing homes and provinces depend on the NHA to meet the needs of elderly persons. Without the NHA only private, profit nursing homes would be viable.

Each of these points have some validity. However, counter-arguments can be presented in most cases, for example:

- although the national proportion of 56.1 funding allocated to nursing homes is small, regionally the proportions are quite high in provinces such as New Brunswick. When a substantial part of available federal subsidy dollars are allocated to nursing homes, other housing needs may not be receiving appropriate attention.
- while providing housing alternatives and meeting special needs has been recognised as an appropriate role for CMHC housing policy, the federal assistance for care facilities is already provided through Health and Welfare Canada. To involve two federal agencies in subsidising nursing homes results in duplication. If federal policy were to provide capital support for these projects, the more appropriate route would be through Health and Welfare rather than CMHC.
- although current CMHC policies require that the 56.1 assistance be applied to the shelter portion of costs only, reduction of total project operating costs has the effect of reducing the amounts of provincial subsidies required (given that resident contributions are pre-determined under provincial programs). Thus, the main benefit of the 56.1 assistance is in reducing provincial expenditures resulting in an inter-governmental fiscal transfer.
- it is certainly true that at present there are few alternative capital funding vehicles (aside from Alberta's programs and private nursing home financing with or without NHA insurance). This may be less than a convincing argument for continued CMHC involvement. Constitutionally, provision of care facilities has been identified as a provincial responsibility. Programs for these facilities are under provincial auspices and control. It is,then, largely a provincial matter to determine how to finance development of the necessary facilities. The Federal vehicle to assist the provinces in this regard is the unconditional EPF financing.

Other issues have been raised with respect to the use of a federal housing subsidy to assist non-profit sponsors of nursing home projects. By encouraging the private non-profit care sector, the involvement of other care providers may be discouraged,notably the provincial,municipal and private care alternatives. This can hardly be taken as a criticism of the federal program which was not designed to assist nursing homes at all. Rather, the mix of project types is a function of provincial programs and those projects which provinces are willing to support.

At the very broadest governmental level, it has been shown that the degree of federal control,not to mention visibility, is extremely constrained under the current operating practices for nursing home funding through Section 56.1. It may be difficult in these conditions for the federal agency to be truly accountable for the funds disbursed.

Valid rationales may be presented from either the pro- or con-nursing home stance. The weight of the evidence does not appear over-whelming on either side. In the abscence of the usually political sensitivities about federal intrusion into areas of provincial responsibility, and given the politically positive aura associated with providing for the aged and infirm, it may be difficult to present a strong case for complete reversal of current policies. Perhaps the major unresolved question is the extent to which federal funding displaces provincial expenditures and results in an inter-governmental fiscal transfer.

4.2 The Need for Housing Subsidies in Nursing Homes

Nursing homes provide accommodation and care for persons no longer able to care for themselves in their own homes or with relatives or friends. Generally, they require some amount of nursing supervision and care as well as assistance with daily living. Aside from Alberta which provides capital assistance for nursing home construction through its Home Mortgage Corporation, provincial departments of housing are rarely involved in provincial nursing home programs. As we have seen, the responsibility rests with social service and/or health departments.

Provincial governments have not seen fit to provide housing subsidies for nursing home projects. To the extent that any capital financing is available it generally provided through the program delivery agencies.

In this situation, the involvement of the federal housing agency in capital assistance for nursing homes seems somewhat anachronistic.

The fact that Section 56.1 funding is being used seems to stem from the availability of the funding and the CMHC policy of permitting use of these funds for nursing homes rather than to any inherent necessity for their use. It would be surprising if provincial governments did not seek to utilise such low-priced capital sources rather than being obliged to borrow the capital funds at market rates of interest.

Provincial use of 56.1 capital assistance is made more understandable in light of the changes in federal operating assistance under the 1977 EPF arrangements. Whereas prior to 1977, Ottawa was required to share 50 percent of provincial expenditures for nursing home and residential care homes, the post-1977 arrangements have placed a ceiling on the federal contribution even though the per capita base amount is escalated each year. With a period of high and rising interest rates, provincial borrowing to finance nursing homes would have resulted in high debt retirement costs which would have fallen on provincial treasuries for repayment. Provinces would have been unable to pass-through the higher costs even on a cost-shared basis to Ottawa. The coincidence of the EPF arrangements with the 1978 NHA Amendments was fortuitous from the provincial stand-point.

There seem to be no a priori grounds for arguing that housing subsidies are necessary for the development of nursing homes. In the absence of these subsidies, other methods of financing would have to be adopted, and the extra costs borne elsewhere. It is self-evident that projects funded with 2 percent mortgage interest rates will entail lower operating costs than if they were developed at market rates of interest. The fear that provinces would be unable to meet the 'needs' for institutional care that are increasing with the aging population seem to be a weak basis for continuing the use of federal housing subsidies. Much of the pressure for development of nursing home projects in provinces such as New Brunswick, Quebec and British Columbia is based on provincial needs estimates. Presumable, it would be a matter of

provincial responsibility to ensure that the needs were met in some other manner, and through provincial resources. Certainly , no other sources of federal capital assistance for nursing homes exist at present.

4.3 The Beneficiaries of Section 56.1 Assistance

Housing subsidy programs are generally predicated on an assumption that provision of subsidies will reduce the shelter cost burden to recipients.The application of Section 56.1 subsidies to nursing homes seems to have little potential for reducing resident shelter costs in most cases.

The situation in Homes for the Aged or boarding/hostel accommodation is quite different from nursing homes where provincially-determined resident per diem charges are set. In the Homes for the Aged in Ontario, or in hostel-type programs, the provincial contribution if any is generally pre-determined and residents must met the balance of the expenses. In these cases, a housing subsidy such as 56.1 would have the effect of reducing the charges to residents in a substantial way given high market interest rates.

However, in nursing homes, the resident contribution is set in relation to the resident's income in the first instance. For those individuals with only the OAS/GIS income, the minimum charge is set as a proportion of their income. Under the health insured programs, all residents pay this amount. Under the social service type programs, higher income residents tend to pay an increasing amount up to the full cost. Thus, for the projects covered by health insured benefits, the use of 56.1 subsidies would have no effect on the residents' contribution. In the non-insured programs, the 56.1 subsidies would have no effect on the contribution of the lowest income residents. However, higher income residents could pay less since the break-even level net of the 56.1 assistance would be lower. Since we have no income profiles of residents in the projects funded it is impossible to assess the extent to which residents may be benefitting from the subsidies under 56.1. However, we may be assured that there are no benefits conferred on the lowest income residents.

If most of the residents in nursing homes are not benefitting financially from the 56.1 subsidy, the benefit has to accrue to the province by reducing the required provincial contribution. Where the provincial subsidy is the operating deficit (the difference between actual operating costs and resident contributions) and where 56.1 subsidies reduce that project operating deficit , most of the net saving would be passed on to the province. However, where provinces fix the maximum per diem rates for both residents and the provincial contributions, then a net saving could accrue to the province only if the break-even cost net of resident per diems was lower than the maximum provincial rates. Since only non-profit projects are assisted through 56.1 there should be no 'surplus' from project operations.

Two scenarios could be postulated under which inter-governmental fiscal transfers may arise from use of Section 56.1 funding. The differences relate to the basic distinction between health insured and non-insured,social service program mechanisms.

Scenario 1: Health-insured Programs

Conditions: Flat rate,fixed resident per diem contributions
No maximum on provincial per diems, provinces fund operating deficits

Total operating costs less the 56.1 subsidy = net cost
Net cost - resident per diems x number of beds = net operating deficit
Net operating deficit = provincial contribution

Scenario 2 : Social Service Programs

Conditions: Minimum resident charge a % of OAS/GIS
No fixed provincial contributions per diem

Total operating costs less the 56.1 subsidy = net cost
Net Cost - resident contributions = net operating deficit
Net operating deficit = provincial contribution

In the second Scenario, the amount of the resident contribution would vary with income up to the full break-even cost. Depending on the income levels of residents, the net saving from the 56.1 subsidy could accrue to the resident or the province.

Lack of income data makes it impossible to estimate the actual shares. However the limiting cases would be :

(i) if all residents were at the minimum OAS/GIS income level, 100% of the saving would accrue to the province

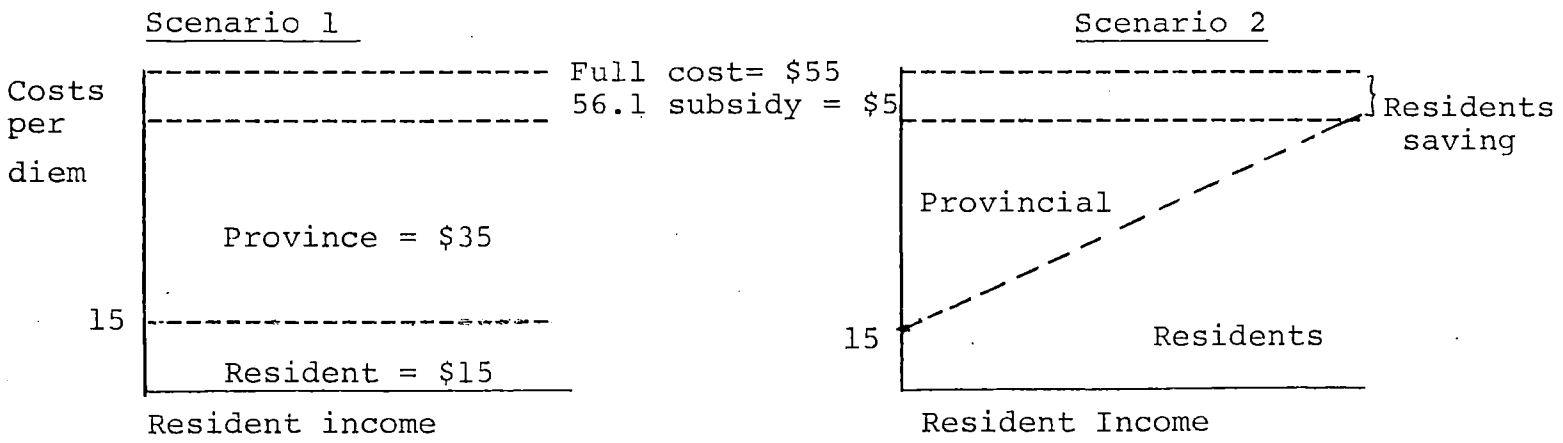
(ii) if all residents were able to pay full cost, there would be no net saving to the province.

The signifiance of the net savings to the province and the resident can be assessed from a hypothetical example. Assume that:

- Total project operating costs (ex. 56.1 subsidy) = $ 55. p.d.
- The 56.1 subsidy equates to $5. per bed per diem

Under Scenario 1, the residents pay a flat rate per diem, say $15. per day. The net saving to the province is equal to the $5. per diem per bed. As a proportion of the provincial subsidy required, the 56.1 assistance reduces provincial contributions by 12.5 percent ($5 dollars as a percentage of $55- 15). There is no net saving to residents.

Under Scenario 2, assuming that residents were required to pay the same $15. per day and that all residents were at the minimum OAS/GIS income, the net saving to the province would be in the same proportion , 12.5 percent. However, if residents were able to contribute the full-cost before the 56.1 subsidy were applied, then these residents would be saving $5 dollars per day as a percentage of $55 , approximately 9 percent. Except for those residents who were able to pay the full-cost, the net saving always accrues to the province in the amount of 12.5 percent of provincial contributions.



While a 12.5 percent provincial saving on the operation of those beds funded through 56.1 represents a small amount on per diem bases, the total saving on all beds could be in the range of $5. million (calculated as $5 a day on 365 days for 3,000 beds).As discussed in Section 2, the bulk of federal Health and Welfare funding for nursing homes is in the form of unconditional per capita grants. Thus, little of this saving would be passed on to the federal government through residual CAP cost-sharing arrangements. It represents a net reduction in the direct costs to provincial treasuries for operation of nursing home accommodations.

The fact that some inter-governmental transfers may occur through the use of 56.1 capital assistance begs the question of whether the projects developed would have been built without the NHA program funding. Most of those contacted have argued that the volume of activity has been highly dependent on the availability of 56.1 funding. Certainly if the same projects had been developed through conventional financing without 56.1 subsidies, the costs to provinces would have been higher. However, it seems unlikely that in most provinces such active programs of nursing home provision would have been undertaken. If this is the case, then the 'savings' to the provinces are hypothetical in so far as they have had to increase their expenditures for the balance of operating costs on these projects.

As 56.1 assistance presently applies, it is difficult to determine how the reduction of provincial subsidies could be avoided without a direct pass-through of the net savings to the residents. This would lead to inequities in charges for residents within the stock of nursing homes and would produce variable rates of resident contributions among projects since the federal subsidy amount varies with the interest rate spread between the actual rate and 2 percent.

4.4 The Federal Role and Control

The federal role in assisting nursing homes is that of financial assistance. After initial project approval and commitment of funds, there is limited CMHC involvement in project monitoring. All financial standards regulation functions are the primary responsibility of the provincial agencies. The extent to which Ottawa may be concerned with the division of responsibilities may be assessed in relation to the relative contributions of the two senior levels of government.

In this regard, it has been assumed that the federal dollar contribution is relatively small when compared with the provincial dollars involved. Even if the federal subsidy equated to 25 percent of total project costs, the provincial contribution is generally twice that level, the balance being from resident contributions The implication is that provincial agencies have valid concerns about cost controls and that they have a large interest in ensuring the efficient operation of these facilities. Such a view may rationalise the limited extent of CMHC involvement in reviews of project operating statements. However, it ignores the broader funding context.

Examining the actual sources of funds applied in nursing home projects is difficult because the forms of federal assistance vary. Indeed, the federal 56.1 assistance may be the more visible of any of the federal contributions, partly because the payments are made on a project by project (or loan by loan basis). However, a large part of the provincial contributions and the residents' payments are also assisted financially by Ottawa.

In a hypothetical nursing home project assisted under section 56.1, the major cost items are as follows:

Amortization expenses	= 20 %
Living /supplies	= 10 %
Salaries for care staff	= 70 %

(Based on review of small sample of projects and CMHC branch staff estimates of 'typical' projects).

The major sources of revenues to cover these costs are, say,

56.1 assistance = 10 %

Residents = 20 %

Provincial contribution= 70 %

If the residents' contributions are considered to apply to the balance of shelter costs not covered by the 56.1 assistance plus living expenses (e.g. food), the provincial contributions are covering the salaries for care staff.

The first two sources of revenue(56.1 and residents) are derived from federal sources (the NHA subsidies and the federal OAS/GIS). The amount contributed by provinces are partly federally assisted under EPF and CAP. While there are no cost-sharing requirements (or required provincial matching of federal dollars), it would be reasonable to assume that at least half of the funding for care costs comes from federal transfers to the provinces. (In some provinces, the ratio of EPF entitlements to total provincial spending on the related programs is more like 60:40 or 70:30). Under these assumptions, roughly 70 percent of the dollars used to support the operation of nursing homes have their origin in Ottawa. The provincial expenditures from solely provincial sources is close to the 30 percent level.

Viewed in this context, two points are worth emphasising. First, the total federal contributions to nursing homes is substantially greater than provincial contributions. Thus, while the provinces provide the delivery mechanisms and regulate the institutions involved, the Federal Government is a major contributor to care facilities for the elderly (and others in the population). Secondly, the federal 56.1 subsidy is generally less than the actual provincial expenditures from provincial sources, but the magnitude of the difference is less significant than would appear from cash-flow treatment of revenues.

In any event, the amounts of federal subsidies provided through Section 56.1 are large enough that a degree of accountability for the funds seems warranted. Current operating practices do not seem to provide for this accountability even where funding is delivered directly by CMHC. The situation with respect to provincially delivered,global allocations is even less satisfactory from an accountability perspective. This may be a matter of greater concern than the issue of federal 'visibility' which is undeniably low in the case of nursing home projects assisted.

A case could be made that the form of the 56.1 federal assistance is sufficiently different from the other federal funding through Health and Welfare as to warrant a higher degree of federal involvement in monitoring and control. First, CMHC funding is provided for specific projects rather than as general program support. Secondly, the funds are allocated to non-profit institutions rather than to individuals or to the provinces themselves. Provincial regulation of the non-profit corporations applies in all cases and is not felt to obviate the need for federal scrutiny in other non-profit projects assisted.

Alternatively, if it is deemed appropriate to lodge control and monitoring with provincial agencies, some modifications in the form of the federal subsidy assistance may be desirable to reduce federal exposure.

The issues of control relate directly to a concern about the extent of provincial commitments to support nursing home projects assisted through 56.1. While initial 'assurances' are provided by provincial governments that the province will continue to provide necessary operating subsidies, the federal 56.1 assistance is a much more permanent guarantee of project assistance than provinces have provided. Particular concern is warranted where provincial nursing home licences

are granted to the operators of the institutions rather than to the institutions themselves. In theory,at least, the operator would be able to sell the licence seperately from the building. CMHC could potentially be left with a nursing home building and no provincial licence for its operation. The marketability of purpose-built care facilities has been questioned and the potential claims on the Mortgage Insurance Fund could be considerable.

Without discussing underwriting risk issues perse, some comments may be offered with respect to the security of provincial funding for nursing home projects. In the first place, the non-profit nursing home sector is highly regulated and controlled by provincial departments. In most cases, provisions have been made for provincial assumption of operation where the current operators fail to provide adequate management or service. The provincial governments may undertake interim management, and appoint a new board or management . Secondly, the likelihood of provinces withdrawing from financial assistance for elderly persons in needs of care is extremely remote. Traditionally, provinces have had wide arrays of provincial programs and policies to assist the elderly. Even under budget constraints, the levels of provincial assistance have generally been maintained in these types of care facilities. While a trend may be anticipated toward adoption of maximum provincial per diem ceilings particularly if programs are converted to a health insurance base, the levels of support would probably be based on the existing levels of assistance. Thus, in projects developed thus far with 56.1 funding, withdrawal of provincial contributions seems a remote eventuality. Therefore, although the federal 56.1 subsidy is a long-term commitment to retirement of specific debts with private lenders, it is quite reasonable to expect that provinces will continue to honour their initial commitments to support the projects financially.

4.5 Summary and Conclusions

Section 56.1 of the NHA has been used in most provinces to assist the development and operation of nursing home services and facilities; federal housing subsidy assistance has been provided as a matter of practice rather than a matter of policy. Although a relatively small proportion of housing subsidy dollars have been used for this purpose since 1978, the federal support has contributed to a major portion of the additional beds provided.

Many arguments have been presented for and against the use of 56.1 funding for nursing home projects. However, there is no over-whelming evidence on either side of the argument. Certainly there are no alternative sources of funding available federally to assist with capital costs. A few provinces have provided capital funds, but most depend on the availability of 56.1 funding. Provincial governments have generally not provided assistance for nursing homes through their housing agencies, most of which have no involvement in institutional care projects. It seems that NHA assistance has been used because it was available rather than because it was essential or necessary. Provision of care facilities is a matter of provincial jurisdiction and responsibility as was recognised in revisions to the federal CAP funding mechanism in 1977.

As a housing subsidy, 56.1 assistance does not seem to delivery benefits to residents in the form of lower shelter costs, although it could be argued that without the NHA program, nursing home projects may not have been provided in many provinces. To the extent that any 'savings' are generated by the 56.1 subsidy, the bulk of the benefit is accrued to the provincial funding agencies in lower provincial contributions. The magnitude of the inter-governmental transfers involved is about 12 percent of provincial contributions.

A large proportion of the costs of operating nursing homes is provided by the Federal Government through health care funding, income transfers and the housing subsidy. On average, provincial governments probably contribute less than 30 percent of the operating subsidies from their own sources. Among the various forms of federal contributions, the 56.1 assistance is probably among the most visible because it is project specific.

Operating practices have tended to emphasise provincial control and regulation and minimize the extent of federal involvement after initial 56.1 funding and construction. Yet the federal housing subsidy is contributed each year for the life of the mortgages, and may represent a more binding commitment than annual provincial budget allocations for operating subsidies. Nevertheless, continuity of provincial assistance in one form or another seems quite assured given past experience.

Thus, while a federal housing subsidy may not be necessary for nursing homes in Canada, post-1978 experience suggests that it has been most useful to allow the expansion of care facilities to meet a wide range of needs. Indeed, the availability of funding may have encouraged some provinces to move forward with projects that would otherwise not have been developed. To this extent, the NHA funding has proved useful for increasing the alternatives and availability of accommodations for the elderly. On the other hand, the case for utilising NHA funding for these purposes is not clear. Certainly, in its present form, the 56.1 subsidy results in most of the financial benefits being transferred to provincial governments as lower provincial contributions. The structure of provincial programs does not permit a direct benefit to residents in the form of lower shelter costs. In large measure, CMHC has been responding to provincial initiatives in funding projects under the terms of provincial funding arrangements and based on provincial assessments of needs. CMHC may wish to consider the extent to which needs for special purpose housing such as nursing homes should be balanced with other housing needs in apportioning its available subsidy dollars.

FOOTNOTES

(1) Canada Mortgage and Housing Corporation, Nursing Homes and Hostels with Care Services for the Elderly,Design Guidelines, 1979, Ottawa, p. 4.

(2) Op. cit., p. 5.

(3) Data from the 1977/8 Annual Returns on Residential Special Care Facilities show that there were 88,701 residents over age 65 in these types of homes. The elderly represented some 88% of all residents in these homes. The break-down of types of care show that among the elderly residents, 67.2% were in 'no care' residences, 1.8% in Type 1 (personal care), 2.2% in Type 2 (nursing care) and 28.8% in Type 3 (intensive nursing and medical care). These data appear to overstate the extremes of the care continuum possibly because of the difficulty of distinguishing among the intermediate categories. This method of classification does not seem appropriate for disaggregation of care facilities.

(4) From information provided to us from the Nealth Insurance Division of Health and Welfare Canada (July,1983).

(5) The current OAS/GIS maximum for a single person is $514.35 ($256.67 OAS plus $257.68 GIS) (July 1983) as obtained from Health and Welfare Canada.

(6) The study entitles Needs of the Elderly was prepared by A.W. Cluff and P.J. Cluff for the Health Facilities Design Division, Health Services and Promotion Branch of Health and Welfare Canada, April 30,1981. It examines the entire range of needs of the elderly including shelter, income,health and psycho-social and the program arrangements available at the federal, provincial and municipal levels as well as privately.

(7) The Canadian Governmental Report on Aging, Canada, 1982,p.13.

(8) Some provinces provided additional capital assistance that was 'stacked' on to the federal assistance for seniors rental projects. However, this was not a condition of program funding.

(9) Section 56.1 Non-Profit and Co-operative Housing Program Evaluation, Program Evaluation Division, CMHC, April 1983, p.2.

(10) CMHC Guidelines and Procedures Manual,Section 5.24 Care Facilities.

(11) All CMHC Regional Offices were contacted in this study. In addition, the following CMHC Branch offices were consulted: St. John's, Fredericton,Quebec City, Toronto, Ottawa and Vancouver. (Others contacted were unable to assist because of staff vacations: Montreal,Victoria and Halifax.

(12) These data were provided in the Section 56.1 Program Evaluation Report,CMHC, April 1983, Table 4.57. The data refer to commitments from 1978 to 1981. The cut-off date was established so as to include only projects which may have been completed and occupied for purposes of the surveys undertaken in the evaluation.

(13) CMHC commitment data is extracted from Form 2254. The projects are described according four categories of units or beds:
(i) Senior self contained units
(ii) Senior self-contained beds
(iii) Senior care units
(iv) Senior care beds.
A few of the projects have included self contained units as well as beds. The self contained units were excluded from the calculations of hostel/care facilities.

(14) The Canadian Governmental Report on Aging, Canada,1982,p.100.

(15) New Brunswick's Nursing Home Program is administered by the Provincial Department of Health, but the provisions for service are not an insured benefits.

(16) British Columbia undertook the consolidation of its care arrangements previously operated under Health and Human Resources within the Ministry of Health in 1975.

(17) Close working relationships appear to have been established between CMHC field staff and the provincial ministries of health in BC and New Brusnwick. Possibly health program delivery functions at the provincial levels are more centralised than social service functions which would facilittate co-operation.

BIBLIOGRAPHY (Recent Reports and Documents)

1. Canada Mortgage and Housing Corporation

o Nursing Homes and Hostels with Care Services for the Elderly, Design Guidelines, CMHC, 1979.

(Background reports and research papers 1 to 12 prepared by Cluff & Cluff).

o CMHC Guidelines and Procedures Manual.

o Section 56.1 Non-Profit and Co-operative Programs Evaluation, Program Evaluation Division, CMHC, April,1983 (Draft).

o Gare, John "Underwriting of Multiple Rental Projects with Support Services," Underwriting Division, CMHC, April 1983.

o Memorandum from Dale Falkenhagen, Nursing Homes in the Atlantic Region, June 22, 1983.

o Becker, Keith, Design Guidelines for Rest Homes in Ontario, Study for CMHC, April 1983.

2. Other Federal Government Documents

o Canadian Governmental Report on Aging, Government of Canada, 1982.
(Background reports and papers by Health and Welfare Canada and CMHC).

o Needs of the Elderly, Health and Welfare Canada, 1981, prepared by Cluff & Cluff Associates.

3. Provincial Government Documents

o The Elderly in Ontario: An Agenda for the '80's, Ontario Secretariat for Social Development, December 1981.

o Ontario Campaign for Community Based Services, Brief to Ontario Cabinet Committee on Social Development, March 1980.

o Provincial Housing Programs in Alberta, Alberta Housing and Public Works, September 1982.

o Alberta Housing Corporation, Annual Report, 1981-2.

APPENDIX I

CARE LEVEL DEFINITIONS : F/P TASK FORCE

APPENDIX 1 : LEVELS OF CARE DEFINITIONS

The following summary is extracted from Needs of the Elderly: Health and Welfare Canada,1981, summarising the definitions developed by the Federal-Provincial Advisory Committee on Health Insurance. (pp. 446-7)

" Types of Care for Planning,Development, Administration are Research purposes.

In what follows, five TYPES OF CARE are defined. Each definition of a Type of Care embodies:

1. A general description of the patient needs;
2. The characteristics of the patient or client;
3. Resources required to meet need:
   a) general program content;
   b) special services and equipment required to meet the needs of the patients or clients;
   c) possible delivery sites;
4. The term currently in use referring to the TYPE OF CARE described.

The general descriptions of TYPES OF CARE as defined by the Working Party are set out below:

TYPE 1 CARE: is that required by a person who is ambulant and/or independently mobile,who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to individual condition.

TYPE II CARE: is that required by a person with a relatively stabilised (physical or mental) chronic disease or functional disability who, having reached the apparent limit of his recovery is not likely to change in the near future,who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE III CARE : is that required by a person who is chronically ill and/or has a functional disability(physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of months or years.

TYPE IV CARE: is that required by a person with relatively stable disability such as a congenital defect,post-traumatic deficits or the disabling sequelae of disease,which is unlikely to be resolved through convalescence or the normal healing process,who requires specialised rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitative process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this type of care is dependent on the nature of the disability and the patient's progress, but maximum benefits can be expected within a period of several months

TYPE V CARE: is that required by a person:
a) who presents a need for investigation,diagnosis or for definition of treatment requirements for a known , unknown or potentially serious conditions; and/or,
b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or,
c) who is in the immediate recovery phase or who is convalescing following an accident,illness, or injury and who requires a planned and controlled therapy and educational program of comparatively short duration.

The numerical system is its progression from TYPE I to TYPE V reflects the increasing qualifications, numbers and variety of staff,increased costs

The reader is referred to the above-noted report for a detailed discussion of the components of each care level and the sites where each level of care is provided under various provincial programs.

APPENDIX II

PROVINCIAL PROGRAM DESCRIPTIONS (1982)*

British Columbia	:	Long Term Care Program Intermediate Care
Alberta	:	Alberta Nursing Home Program Lodge Assistance Program Lodge Upgrading Program Unique Homes Assistance Program Senior Citizens Lodge Program
Saskatchewan	:	Special Care Home Program
Manitoba	:	Personal Care Home Program
Ontario	:	Homes for Aged Program Extended Care Program
Quebec	:	Residential Care Programs
New Brunswick	:	Nursing Home Services Program Homes for Special Care Program
Nova Scotia	:	Under the Homes for Special Care Act- Nursing Home Program Homes for the Aged Residential Care Facility Program
PEI	:	Homes for the Aged
Newfoundland	:	Homes for Special Care

* For the most part, the following program descriptions were provided by the Health Insurance Division of Health and Welfare Canada. These represent the most recent information available to Health and Welfare Canada as provided by the provinces under the terms of the EPF Act.

BRITISH COLUMBIA

LONG-TERM CARE PROGRAM

Date It Came Into Effect: January 1, 1978

Authorizing Body: Ministry of Health

Objectives: The Long-Term Care Program (1978) is designed to meet the individual needs of those who, because of health related problems, are unable to live independently. Its aim is to promote the highest level of independence possible for those assessed as being in need of this care, and to provide, where and when indicated, the support necessary to allow the beneficiaries to live as normal an existance in their own community as their infirmities permit.

The long-term care provided by the Program will be readily accessible to all who have need for its services, and will, where possible, be provided in the beneficiary's own community. These services will include a home support service, and, where necessary and available, institutional care in an approved community care facility licensed to provide personal or intermediate levels of care; or, the beneficiary of the Program may be admitted to an extended-care hospital.

Scope of Services: The range of services provided includes the assessment of individual's social needs and care requirements, homemaker/handyman services, meal service, adult day care centres, geriatric assessment and treatment centres, respite care (short-term admission to intermediate, extended and hospice facilities), and residential care from personal care level to extended care.

Also available to beneficiaries are the services delivered through the Home Care Program, and Dental Program.

At present 22 Adult Day Centres are being funded with an additional 10 being considered for approval.

Three geriatric assessment and treatment centres are in operation, located in acute care facilities but funded from the Long-Term Care budget. There is a proposal to extend this program to more centres, possibly 10.

Eligibility: The Long-Term Care Program is available to any resident of British Columbia who, because of health-related problems, is unable to cope and function independently. All ages are included from young adults to the elderly; in some circumstances children are included.

The person must be:
- a Canadian citizen or landed immigrant and
- have lived in British Columbia for the 12 months immediately before applying.

Some exceptions in cases of special hardship may be allowed. All requests for assistance will be dealt with individually.

Note: Entitlement to Extended Care Hospitals continues to have a 3-month residency requirement in British Columbia.

Utilization: (Long-Term Care Facilities)	1979	1980
New assessments	19 683	18 700
Residents already in Facilities	15 247	15 968

Fees:* a) For care in community care facilities - Everybody pays the same basic amount of $~~$10.50/day as of July 1, 1981~~, and pays it to the facility. This charge entitles the person to standard accommodation and to the quality of care that the Community Care Facilities Licencing Board (Ministry of Health) expects the facility to provide every person. Charges for room differentials range from $3. to $9. No hidden charges can be made for what should be provided.

b) There is no charge for homemaker services when the family's (individual's) monthly income falls below certain levels. The formula used to assess monthly incomes takes into consideration such factors as:
- the number of people over age 65 in the family
- the number of handicapped people in the family
- the earnings of some family members.

c) Home Care Category I - Non-Hospital Replacement, clients receive professional nursing/health care and most equipment free of charge, but are responsible for the cost of purchased services such as homemaker services, meals-on-wheels, etc.
Home Care Category II - Hospital Replacement clients receive all professional nursing/health care as well as purchased services free of charge.

Funding:

Administration	5%
Payment to service providers	95%

---

* for detailed fee information consult the individual Profiles

Of the 95%:	Residential facilities	70.2%
	Homemaker Services	26%
	Adult Day Care Centres	1.75%
	Assessment and Treatment Centres	2%

Total Budget:

1979/80	$134 000 000
1980/81	$170 000 000
1981/82	$212 000 000

Out-of-Province Benefits: None

B R I T I S H C O L U M B I A

LONG-TERM CARE PROGRAM: INTERMEDIATE CARE:

Date It Came Into Effect: The Long-Term Care Program was introduced January 1, 1978.

Authorizing Body: Ministry of Health

Objectives: To provide long-term care in an approved community care facility to that segment of the population for whom it is neither desirable nor practicable to care for in their own homes. Where possible, this accommodation will be provided within the beneficiary's own community.

Scope of Services: Intermediate Care is structured to provide three levels of care. The basic services provided by all three levels are:

- 24 hours a day supervision by non-professional personnel;
- daily supervision by health professional staff;
- necessary assistance with the activities of daily living such as dressing, washing, grooming and bathing;
- a protective and supportive environment;
- a planned program of social and recreational activities;
- supervision of medications and the changing of surgical dressings;
- therapeutic dietary supports (diabetic and other special therapeutic diets);
- specialist services as required i.e., physiotherapist, occupational therapist, speech therapist.

The three levels of care differ in the amount of individual care provided each day.

Level 1 - resident receives a minimum of 75 minutes of available individual attention during each 24 hour period as follows:
i) professional - 15 minutes/day;
ii) non-professional - 60 minutes/day.

Level 2 - resident requires approximately 100 minutes of available individual attention in each 24 hour period as follows:
i) professional - 30 minutes;
ii) non-professional - 70 minutes.

Level 3 - resident requires at least 120 minutes of individual attention during each 24 hour period as follows:
i) professional - 30 minutes;
ii) non-professional - 90 minutes.

Eligibility: The Long-Term Care Program - Intermediate Care is an insured benefit with a user fee charged. Eligibility is tied to the two general criteria of residency and need for services.

Residency - open to B.C. residents 19 years of age and over;
- must be Canadian Citizen or Landed Immigrant who has resided in B.C. for 12 consecutive months prior to applying for admission to a facility.

Health need - person cannot live without help because of health related problems which cannot be adequately cared for outside of an Intermediate Care Facility.

Utilization:

	1979/80	1980/81
Number of beds	9 343	10 491

Fees: Services are provided as an insured benefit with a ~~$10.50/day user fee as of July 1, 1981~~. $11.50/day APR.82 If the resident cannot pay any or all of this fee, he/she may apply for assistance from the Department of Human Resources. Additional charges may be applicable for special activities (for example to cover the cost of supplies if participating in certain crafts programs), and for preferential accommodation. Charges for room differentials range from $3 to $9.

Funding:

Ministry of Health	69%
Ministry of Human Resources	1%
User charges	30%

Total Budget:
Long-Term Care Program (Total).

1979/80	1980/81	1981/82
$134 000 000	$170 000 000	$212 000 000

Out-of-Province-Benefits: None

A L B E R T A

ALBERTA NURSING HOME PROGRAM

Date It Came Into Effect: 1964

Authorizing Body: Department of Hospitals and Medical Care

Objectives: The Plan offers supervised, personal care to Alberta residents who are not ill enough to require carein an active treatment or auxiliary hospital, but who require assistance in coping with activities of daily living.

Scope of Services: Nursing Home care includes the following services:

- a minimum of 1½ hours of nursing care per day;
- supervision in personal care, mobility, safety, meals and dressing;
- accommodation, meals and laundry;
- special diets as required;
- routine drugs and dressings as ordered by the attending physician;
- recreation and rehabilitative activities.

For residents over 65 years of age additional medical benefits are available through the Extended Health Benefits Program which will cover most of the cost of eyeglasses, dental work, hearing aids and certain medical equipment.

Eligibility: The program is designed for those Alberta residents who are no longer well enough to be cared for at home or in facilities such as Senior Citizens' Lodges, but not ill enough to require an active treatment or auxiliary hospital.

Criteria for admission to the program are:

- any person who has established their home in Alberta for 3 consecutive years immediately before applying for benefits, or for a period of at least 10 consecutive years at any time before applying, and;
- has been found to require care in a nursing home by a duly appointed assessment committee.

Persons who are ineligible for nursing home care because they do not meet the residency requirement may be admitted to a nursing home, however they will be expected to pay for the full cost of their care.

Utilization:	No. of Nursing Homes	No. of beds
March 1979	77	7 025
March 1980	78	7 132
March 1981	80	7 286

Fees: The cost of care in nursing homes is paid as an insured benefit under the provincial hospitalization plan. Residents are required however to pay a daily rate charged by contract nursing homes. The current rates as of ~~April 1981~~ MAY 82 are as follows:

8.00 - ~~$7.00~~ per day for standard ward accommodation;
10.50 - ~~$9.25~~ per day for a semi-private room;
14.25 - $~~12.50~~ per day for a private room.

These rates are annually upgraded.

~~For those persons who do not meet the resident of Alberta criteria there is an additional charge of $12.50 per day.~~ NOTE: non-residents pay ward charge + Dept. portion

In addition to the money the client pays directly to the contract nursing home operator, the Alberta Department of Hospitals and Medical Care pays to the operator the following amount (~~effective April 1, 1981~~: MAY 82

a) for contract nursing homes of 50 beds or less

31.55 - ~~$25.75~~ for each day an eligible client is in the nursing home or on a short term leave of absence as outlined in the regulations, or

28.00 - $~~22.75~~ for each day an eligible client is on an extended leave of absence as outlined in the regulations;

b) for contract nursing homes of 51 to 100 beds

30.45 - $~~24.75~~ for each day an eligible client is in the nursing home or on a short term leave of absence as outlined in the regulations, or

27.00 - $~~21.75~~ for each day an eligible client is on an extended leave of absence as outlined in the regulations.

c) for contract nursing homes of 101 beds or more

30.20 - $~~24.50~~ for each day an eligible client is in the nursing home or on a short term leave of absence as outlined in the regulations, or

27.00 - $~~21.75~~ for each day an eligible client is on an extended leave of absence as outlines in the regulation.

Assistance in paying per diem charges may be available upon review by the Department of Social Services and Community Health.

Funding:	1979/80	1980/81
Alberta Department of Hospitals and Medical Care	72.05%	73%
Client co-payment	21%	20%
Other sources:		
Preferred Accommodation	3%	3%
Itemized	4%	4%

Total Budget: 1979-80 $59 814 838
1980-81 $ 62 942 250

Out of Province benefits: None

ALBERTA

1. The Nursing Homes Act

Resposnibility : Department of Hospitals and Medical Care, Institutional Operations Branch

Extended health care benefits are available. Programs and services include nursing care, diet and special diet, reactivation, remotivation and therapi relevant to individual patients.

Residency requirements: patient must have resided in Alberta three consecutive years previous to application or 10 consecutive years at any one time. Admission is on medical assessment of need by physician.

2. Nursing Home Financing Program

Responsibility: Department of Housing and Public Works, Alberta Home Mortgage Corporation

Purpose : to provide loans to voluntary non-profit organisations for the construction of nursing homes.

AHMC will provide loans at its conventional rate to approved applicants up to 95% of construction cost plus the mortgage insurance fee to to a current maximum of $27,000 per bed.

3. Senior Citizen Lodge Program

Responsibility: Alberta Housing Corporation and Senior Citizen Foundations

Purpose: To provide housing to senior citizens at rates they can afford in both urban and rural areas

The program provides room and board accommodation to senior citizens who do not wish ot cannot handle their own housekeeping, as determined personally or through a physician. Rental guidelines are set by the provincial government. Local foundations manage each lodge.

Admission requirements: reasonable mental and physical health, Alberta residency for one year prior to application, age at least 65 (if a couple, one has to be 65)

The total cost of construction of lodges is paid by the province and municipalities are asked to pick up any deficits in the shortfall between rents collected and operating costs.

4. Lodge Assistance Program

Responsibility: Department of Housing and Public Works.

Purpose: to ease the municipal tax burden of supporting lodges by making contributions to municiplaties whose lodge support deficits are significant relative to the local property tax assessment base.

Eligible municipalities are those which have contributed financially to support lodges in the previous year and whose lodge support deficits are larger than the amount corresponding to two mills of the local property tax base. The Province will contribute a grant of 50% of the amount in excess of a two mill rate.

5. Lodge Upgrading Program

Responsibility: Alberta Housing and Public Works, Alberta Housing Corp.

Purpose: To provide financial assistance to lodges for essential capital improvements. Upgrading ietms include fire alarms systems, the installation of controls on domestic hot water systems etc.

6. The Unique Homes Assistance Program
Responsibility: Department of Housing and Public Works.
Purpose: to provide grants to eligible senior citizens homes to pay a portion of their operating deficits.

Eligible homes are those which provide lodge type accommodation, are occupied primarily by seniors, are owned and managed by non-profit corporations, provide levels of care which on average fall between thoat provided in lodges and nursing homes, and are ineligible for assistance under the Nursing Homes Act.
Eligible homes may be awarded grants of 75% of justifiable deficits which are defined as the deficit resulting from the shortfall between revenue from patient contribitions and investment income and eligible costs of care and services up to $3.75 per patient per day.

Source: Needs of the Elderly: Health and Welfare Canada, 1981, and Provincial Housing Programs in Alberta, 1981.

DRAFT / ÉBAUCHE

S A S K A T C H E W A N

SPECIAL-CARE HOME PROGRAM

Date it Came into Effect: 1965

Authorizing Body: Department of Social Services

Objectives: The main objectives of the Program are:
to license and regulate special-care homes to ensure that the required care and physician and administrative standards are met.
to co-ordinate the overall development and partially fund the construction of residential care beds.
through effective assessment and placement policies and techniques to match care needs of the elderly and disabled with programs and facilities to meet these needs.

Scope of Services: Services under this program are roughly equivalent to Types I, II and III care as defined by the federal/provincial Working Party on Patient Care Classification. Not all facilities provide all levels of care, however, services that are common to all facilities are:
- accommodation at the ward level;
- meals prepared according to Canada's Food Guide;
- social, recreational and physician programs;
- religious services;
- approved drug regimens and special diets as ordered by the attending physician; and
- some nursing and medical supplies.

Eligibility: The program is available to any resident of Saskatchewan regardless of their period of residency. Persons are admitted to facilities by applying directly to the home of their choice. A physician must provide the medical assessment and the admission committee will review the application.

Fees: All residents requiring Levels II, III, or IV care pay a standard resident charge of ~~$390 per month~~ $417/month APR/82. The Department provides operating funds according to determinations following a budget review process. There is no provision of funds for residents requiring Level I care except when in need. Financial assistance would then be provided through the Saskatchewan Assistance Plan. This aid is available to those residents requiring the other levels of care if they are financially eligible.

Utilization: There are 136 special-care homes licensed. The numbers of licensed beds as of January 1981 are as follows:

Level I	1 008
Level II	2 071
Level III	4 588
Level IV	1 307*
	8 974

* Beds shown for Level IV include 502 designated long-term care beds in general hospitals or operated by hospitals.

There will be an additional 120 beds constructed in 1982/83.

Funding Sources: Not available at this time.

Total Budget: Not available at this time.

Out-of-Province Benefits: None

M A N I T O B A

PERSONAL CARE HOME PROGRAM

Date Program Came Into Effect: July 1, 1973

Provincial Authority: Manitoba Health Services Commission (MHSC), Department of Health

Objectives: To provide care for people who are unable to live in their own homes because of their need for care, but do not require the services of an acute or extended treatment hospital.

Scope of Services: The Personal Care Home Program provides three types of care similar to those defined by the Federal/ Provincial Working Party on Patient Care Classification. Residents and applicants are assessed at a level of care (1,2,3, or 4) indicating the demand on staff time to meet needs for care and supervision. The terms hostel, personal care, and extended care describe the types of care provided by facilities.

Manitoba Hostel Care as provided to level 1 resident
- Federal Type I equivalent

Manitoba Personal Care as provided to level 2 resident
- Federal Type II equivalent

Manitoba Extended Care as provided to level 3 resident
- Federal Type III equivalent

The difference between these three levels of care is the amount of personal/therapeutic care and supervision given each day.

Generally described the services include:

- accommodation at the standard ward level;
- meals including special and therapeutic diets;
- necessary nursing services;
- routine medical and surgical supplies;
- prescribed drugs, biologicals, and related preparations approved by MHSC;
- physiotherapy and occupational therapy where approved by MHSC;
- routine laundry and linen services;
- other goods and services approved by MHSC.

Eligibility: To be eligible for these services a person must have resided in the province for 24 consecutive months prior to admission or, have previously resided in Manitoba for a total of 30 years or more.

For those persons who do not meet these eligibility criteria, admission into a personal care facility is possible depending on space availability, however they will be expected to pay for the full cost of care which could amount to $10.75 per day (usual residency charge as of March 31, 1982) plus an additional charge based on actual cost of care provided which could total up to $45.00/day.

Utilization: Personal care homes are operating at close to 100% utilization with the exception of those facilities designated for hostel care only. Persons requiring level I care are now being maintained in the community on the Home Care Program and the need for this type of care is decreasing. As of March 31, 1982 there are 115 personal care homes with a rated bed capacity of 8 038 beds (5 573 non-proprietary beds and 2 465 proprietary beds).

Fees: The Program is funded as an insured benefit with residents being required to pay a per diem user charge. The residential charge as of ~~March 31, 1982 is $10.75.~~ May 1, 1983 is $12.55

Funding: The non-proprietary personal care homes submit an annual operating budget which M.H.S.C. reviews, adjusts and subsequently approves on a global basis.

The proprietary personal care homes are paid the median rate of the non-proprietary personal care home budgets for care according to the assessed care levels of residents in the facility.

	1980/81
Province of Manitoba Consolidated Fund	76.4%
Residential Charges	23.6%

Total Budget:

1979-80	$70 559 000
1980-81	$81 678 000
1981-82	$99 958 000

Out-of-Province Benefits: None

ONTARIO

HOMES FOR THE AGED PROGRAM

Date It Came Into Effect: 1970

Authorizing Body: Ministry of Community and Social Affairs (COMSOC)

Objectives:

Scope of Services: Services generally provided include:

- nursing and/or personal care up to 1½ hours of care per day per resident, under the direction of an attending physician or a physician assigned to the home;
- a physician assigned to the home to oversee the organization of medical and nursing services and to act for residents who have no attending physician;
- organized social, physical, recreational and religious activities for residents;
- approved diet and management of prescription drug regimens;
- modified and therapeutic diets as ordered by physician;
- medical and surgical supplies, orthotics and prosthetics, hearing aids, etc;
- under the Ontario Drug Benefit Plan, all Ontario residents 65 years of age and older receive free prescription drugs.

Only Type 1 residents, ie those requiring less than 1½ hours of care per day, are eligible for residential care under the Homes for the Aged Program. However, those residents whose condition deteriorates to Type 2, ie they require up to 2½ hours of care per day, may remain in the facility and be covered under the Extended Care Program. At that point in time, the client would receive, and be charged for services, as if resident in a facility of the Extended Care Program.

Eligibility: Client eligibility is dependent upon the following criteria:

- over the age of 60 years and either incapable of properly caring for oneself, or requiring supervision due to mental incompetency;

- over the age of 60 years and requiring less than 1½ hours per day of skilled nursing and/or personal care; or
- with the approval of the Minister of COMSOC, under the age of 60 years, but because of special circumstances, cannot be cared for adequately elsewhere.

Utilization:	1979	1980	1981
new assessments			
residents already in facilities			

At present the EHCS has no information concerning the number of people covered by this Program.

Fees: If financially able, the resident bears the full cost of residential care. For those residents who cannot pay the full cost of care, the home submits a monthly claim to the province which then will subsidize 70% of the cost of care for municipal homes, and 80% for charitable homes up to a per diem ceiling of $17.50. In addition, to the extent that actual costs exceed the negotiated per diem rate, the province subsidizes the remaining deficit at 70 for municipal homes (as part of the regular monthly claim process) and 80% for charitable homes (on an ad hoc basis).

The per diem rate is negotiated with each home annually, on the basis of demonstrated cost increases, with charitable homes having a residential ceiling per diem of $17.50.

In addition there is an additional resident charge of $286.00 per month or $9.40 per day for private accommodation, and $143.00 per month or $4.70 per day for semi-private accommodation. The Province does not share in the costs for preferred accommodation.

All charges mentioned above are current for the fiscal year 1979-80 and are in effect to April 1980.

Funding: At present the EHCS Program has no information with regards to the cost breakdown for this Program ie percentage of annual cost of Program met by COMSOC, user fees etc.

The capital costs of municipal homes is shared on a 50/50 basis between COMSOC and the municipality. For charitable homes COMSOC covers all capital costs up to a maximum of $5000 per bed, based on construction costs.

Total Budget:	1979/80	1980/81	estimate 1981/82

There is no information currently available.

Out-of-Province Benefits: None

ONTARIO

EXTENDED CARE PROGRAM

Date It Came Into Effect: 1972

Authorizing Body: Ontario Ministry of Health

Objectives: To ensure that persons in nursing homes receive adequate care according to established standards and that the system is controled to match size and distribution with demand.

Scope of Services: Services are usually provided in licensed private nursing homes. However, they are also provided to some residents of homes for the aged who were receiving Type I care and whose condition deteriorated to require Type II care.

Services provided include:

- an advisory physician to oversee the organization of medical and nursing services;
- an emergency physician "on-call" at all times;
- modified and therapeutic diets as ordered by the attending physician;
- physical and recreational activities;
- approved diet;
- management of prescription drug regimen;
- an annual physical check-up given by the attending physician;
- free prescription drugs for all persons 65 years of age and over, available under the Ontario Drug Benefit Plan;
- a minimum of 1½ hours per day per resident of nursing and personal care, under the supervision of a registered nurse/nursing assistant and under the direction of a physician.

Eligibility: The Program is available to any resident of Ontario who:

a) is fully current with payment of their Ontario Hospital Insurance Program (OHIP) premiums (persons 65 years of age and over do not pay OHIP premiums);
b) was a resident for the 12 month period immediately preceeding their application for admission;
c) has a verified need for a minimum of 1½ hours of skilled nursing and personal care per day as attested to by their attending physician.

Utilization:

	Homes	Beds		Homes	Beds
April 1978	367	27 847	March 1979	363	28 079
April 1979	363	28 079	March 1980	356	20 208
April 1980	356	20 208	March 1981	350	28 295

Fees: Services are paid for as an insured benefit under OHIP with a user fee charged to the resident. The current fee structure as of ~~August 1981~~ May 1/83 is as follows:

Per Diem (or)	Per Month	Type of Accommodation
15.19 ~~$12.60~~	$383.24	standard ward
+ 6.15 $17.60	$535.32	semi-private
+ 12.30 $22.60	$687.40	private

140.35 (Hotel)

In addition to the above the province pays ~~$21.40~~ per day or $650.90 per month to the facilities.

The Ministry of Community and Social Services may provide Disability Pension or General Welfare Assistance to meet a percentage of the resident co-payment charge depending upon the financial needs of the individual as assessed by an 'income-needs test'.

Comfort allowance $91.00

Funding:

Provincial Ministry of Health 62-65%
Resident co-payment accounts for the remainder up 100%

Total Budget:

1979-80 (actual)	
Extended Care Program	$14 077 000
* Homes for Special Care	$ 63 698 200
1980-81 (actual)	
Extended Care Program	$163 365 000
* Homes for Special Care	$ 69 237 900
1981-82 (printed estimates)	
Extended Care Program	$183 419 000
* Homes for Special Care	$ 73 079 400

Out-of-Province Benefits: None

---

* Homes for Special Care is the term used in Ontario to describe beds and services, often in nursing homes, which are for persons discharged from psychiatric institutions.

1. GOVERNMENT OF QUEBEC

2. Ministère des Affaires Sociales.

3. Purpose : Intended to provide accommodation for those who are 65+ who require care and supervision.

4. Shelter Programs fall into three categories :

   - The Foster Family - because of its size (a maximum of 9 guests) provides the closest thing to normal living for seniors living in the community.
   - The Pavillion - Accommodates between 10 - 29 people and receives professional support from reception centres to which they are bound by contract. Generally the health of tenants is not as good as that of tenants from the foster families.
   - The Reception Centre - is intended for seniors who require regular assistance to meet their personal requirements. Provides medical care and nursing as well as group activities.

Source: Needs of the Elderly: Health and Welfare Canada, 1981.

NEW BRUNSWICK

NURSING HOME SERVICES PROGRAM

Date It Came Into Effect: Regulations relating to licensing and Program supervision came into effect in 1971. The financial assistance function was transfered from the Department of Social Services to the Department of Health in April 1979.

Authorizing Body: Department of Health

Objectives: The main objectives of the Program are:

- to ensure an equitable distribution of Nursing Home beds in the Province;
- to ensure financial accessibility to the service by providing financial assitance to those unable to meet the cost of their care;
- to ensure the maintenance and supervision of program standards in the Nursing Homes.

With the establishment of the Special Care Homes Program in 1975, primary responsibility for the provision of Level I care (New Brunswick definition) has been removed from the Nursing Home Services Program. It is hoped that in the near future the Special Care Homes Program will totally meet the needs of Level I care clients, with the Nursing Home Services Program providing higher levels of care, primarily Level III (New Brunswick definition).

At the present time, approximately 70% of all residents in Nursing Homes require Level III care.

Scope of Services: The amount of personal and/or nursing care received by a resident of a Nursing Home will depend upon the level of care that they are assessed as requiring. Most residents of Nursing Homes receive between ½ and 2½ hours of care per day (Level I, II, III, - New Brunswick definitions). However, there are residents that require and receive more care. In addition, other services are:

- visits from a medical practitioner on a regular basis;
- basic dietary requirements are met according to the Canada Food Guide, with special diets prepared as and when prescribed by a physician;
- in some facilities physiotherapy and occupational therapy are available;
- physical, recreational and spiritual activities, are provided on an individual and group basis, according to the needs and interests of the residents;
- reassessment of required Level of Care at least once a year by a Public Health Nurse.

Eligibility: There is no minimum residency period required before admission, however applicants are encouraged to have Medicare (for which there is a residency period) in order to ensure their eligibility for medical services insurance. Additional criteria are as follows:

- a medical assessment conducted by a physical within 90 days prior to admission and submitted to the district medical health officer;
- a chest X-Ray within one year prior to the date of admission;
- a nursing care assessment completed by the Public Health Nurse.

Utilization: No figures are currently available.

Fees: The services provided by the program are not insured benefits. Residents of Nursing Homes are required to pay for the care that they receive. Residents who are evaluated by an 'income-needs test' as being unable to pay for any or part of the cost of care will have their monthly rate subsidized by the province. Residents are allowed $70.00 per month as a comfort and clothing allowance and are expected to use the rest of their income to pay for the cost of their care.

Each Home of 30 or more beds negotiates with the province for the rates that it may charge. Only one rate is established per nursing home, regardless of the fact that three different levels of care may be offered, and that rate is the established cost to each resident. For homes with more than thirty beds the rates in 1983 are $46.44 and $75.14.

Rates for the homes with less than 30 beds are fixed by Level of Care. For the fiscal year 1983-84, the rates are:

Level I $16.98/day,
Level II $19.08/day,
Level III $30.57/day,

Funding:

New Brunswick	Department of Health	65%
	Resident Revenue	34%
	Recoveries	1%

Total Budget:

1979-80	$27 000 000 (approx.)
1980-81	$35 000 000 (approx.)

Out-of-Province Benefits: None

NEW BRUNSWICK

HOMES FOR SPECIAL CARE PROGRAM

Date It Came Into Effect: 1975

Authorizing Body: Department of Social Services

Objectives:

Scope of Services: Services provided to residents of Special Care Homes include:

- basic room and board;
- up to 1½ hours per day of therapeutic and/or personal care;
- special or therapeutic diets as prescribed by a physician;
- access to nursing or medical care on a 24 hour basis;
- special medical equipment and supplies as required;
- under the New Brunswick Prescription Drug Program, free prescription drugs are provided to all persons over 65 years of age.

Eligibility: Admission to the Program is assessed by a Public Health Nurse. The criteria used are related to the amount of care generally required and the appropriateness of the type of care provided in a special care home to the overall physical and mental condition of the applicant.

If the determination is made that special care would be the best treatment method, then the applicant would then be referred to several special care homes in the community with the final entrance determination made by the facility operator.

Utilization: No information is currently available on the number of people using this Program.

	1979	1980	1981
new admissions			
continuing residents			
Total			

Fees: The rates established for 1979 charged to residents were based on the Consumer Price Index cost-of-living increases and their effect upon the OAS/GIS payments (with $50 monthly in confort and clothing allowance remaining with the resident). This ment that each resident was expected to pay ~~$9.26 per day or $282.87 per month~~ to the facility. The contribution made by the province to the facility for the cost of care is not available.

389.30
1 June 83

Figures for 1981 are unavailable at this time.

Funding: Amounts for the current period are unavailable.

Percentage paid by: Dept. of Social Services
Department of Health
User fees
other (specify)

Total Budget:	1979-1980	1980-1981	1981-1982

Out-of-Province Benefits: None

N O V A S C O T I A

NURSING HOME PROGRAM

A component of the Homes for Special Care Act

Date Program Came Into Effect: Established in 1958

Provincial Authority: Department of Social Services

Objectives: To provide Types I through II care to those persons who cannot maintain themselves or be maintained in the community.

Scope of Services: There are a number of services provided to residents of "Homes for Special Care" (nursing homes, homes for the aged, residential care facilities). They include:

a) the appointment for every home, of a qualified medical practitioner as a medical health advisor to oversee the organization of medical services and to act on behalf of residents who have no attending physician;
b) the provision of social, educational, vocational, religions and recreational programs and activities in accordance with the interests and abilities of residents;
c) the provision of appropriate and adequate food services;
d) the provision of medical and surgical supplies as required by residents;
e) appropriate management of prescription drug regimens for residents;
f) and the opportunity to work in the home or the community if they are able, however under no circumstances shall a resident be forced to work.

In addition to these general services there are additional services available to residents of nursing homes. They are as follows:

a) nursing and/or personal care up to 2½ hours per day per resident under the direction of a registered nurse;
b) an annual review of residents' clinical condition.

Eligibility: Selection for a specific level of care is made by a Provincial Classification Committee (for those requiring provincial assistance with payments of fees), with the final decision to admit resting with the home administrator. Criteria used are as follows:

a) the person is physically or mentally handicapped (either mentally retarded or past mentally ill) to such a degree that he/she is unable to function independently or with community support in his/her home;
b) the person is 16 years or older;
c) the person's primary need shall not be for the level of medical treatment such as is normally provided in hospitals;
d) the person does not require active and continuous in-patient psychiatric treatment;
e) the person is not dangerous to self and/or others and does not behave in a manner which is likely to be constantly disruptive to other residents;
f) the person is stabilized on medications;
g) the person's primary presenting problem is not active involvement in alcohol or drug abuse of any kind for three months prior to admission;
h) the person requires up to 2½ hours per day of skilled nursing and personal care.

Utilization: As of December 1982 there are 1 668 beds in 23 nursing home facilities.

Fees: Nursing home care is ~~not~~ an insured benefit under the Nova Scotia Hospital Insurance Program. Each year the Department of Social Services negotiates with each nursing home to establish a per diem rate for that home based upon the actual costs of providing services. The average per diem rate as of ~~December 1982~~ JAN. 83 is $44.00. The charge to the resident is based upon a means evaluation. A resident may have subsidized all or part of the per diem fee. In those cases where the resident is having some portion or all of the per diem subsidized, the nursing home bills the municipality for the subsidized amount. The municipality recovers two thirds of this amount from the Department of Social Services. → +6%

For those persons requiring assistance with the payment of the fees, they are allowed to retain from their OAS/GIS between $20 to $60 per month as a comforts allowance, depending upon the municipality.

Funding:	Municipal revenue	33 1/3%
	Provincial revenue	33 1/3%
	Federal contribution	33 1/3%

Total Budget:	1979-80	$30 213 680.61
	1980-81	$38 289 000.00

Out-of-Province Benefits: None

N O V A S C O T I A

HOMES FOR THE AGED

Date Program Came Into Effect: Organized under the Homes for Special Care Act, 1976.

Provincial Authority: Department of Social Services

Objectives: To provide Types I through II care to those persons who cannot maintain themselves or be maintained in the community.

Scope of Services: There are a number of services provided to residents of "Homes for Special Care" (nursing homes, homes for the aged, residential care facilities). They include:

a) the appointment for every home, of a qualified medical practitioner as a medical health advisor to oversee the organization of medical services and to act on behalf of residents who have no attending physician;
b) the provision of social, educational, vocational, religions and recreational programs and activities in accordance with the interests and abilities of residents;
c) the provision of appropriate and adequate food services;
d) the provision of medical and surgical supplies as required by residents;
e) appropriate management of prescription drug regimens for residents;
f) and the opportunity to work in the home or the community if they are able, however under no circumstances shall a resident be forced to work.

In addition to these general services there are additional services available to residents of homes for the aged [illegible]. They are as follows:

a) nursing and/or personal care up to 2½ hours per day per resident under the direction of a registered nurse;
b) an annual review of residents' clinical condition.

Eligibility: Selection for a specific level of care is made by a Provincial Classification Committee for those persons requiring provincial assistance with the payment of fees, with the final decision to admit resting with the home administrator. Criteria used are as follows:

a) the person is physically or mentally handicapped (either mentally retarded or past mentally ill) to such a degree that he/she is unable to function independently or with community support in his/her home;
b) the person is 16 years or older;
c) the person's primary need shall not be for the level of medical treatment such as is normally provided in hospitals;
d) the person does not require active and continuous in-patient psychiatric treatment;
e) the person is not dangerous to self and/or others and does not behave in a manner which is likely to be constantly disruptive to other residents;
f) the person is stabilized on medications;
g) the person's primary presenting problem is not active involvement in alcohol or drug abuse of any kind for three months prior to admission;
h) the person required up to 1½ hours per day of skilled nursing and personal care.

Utilization: As of August 1979 there were 79 residential care facilities with 1 091 beds. As of December 1982 there are 70 facilities with 1 074 beds

Fees: Services provided by residential care facilities are not an insured benefit under the Nova Scotia Hospital Insurance Program. Each year the Department of Social Services negotiates with each residential care facility to establish a per diem rate for that home based upon actual costs of providing services. The average per diem rate as of ~~December 1982~~ is [redacted]. The charge to the resident is based upon a means evaluation. A resident may have subsidized all or part of the per diem fee. In those cases where the resident is having some portion or all of the per diem subsidized, the residential care facility bills the municipality for the subsidized amount. The municipality recovers two thirds of this amount from the Department of Social Services.

JAN. 83 20.00 +6%

For those persons requiring assistance with the payment of the fees, they are allowed to retain from their OAS/GIS between $20 and $60 per month as a comforts allowance, depending upon the municipality.

Funding:	Municipal revenue	33 1/3%
	Provincial revenue	33 1/3%
	Federal contribution	33 1/3%

Total Budget: Figures not available at this time.

Out-of-Province Benefits: None

RESIDENTIAL CARE FACILITY PROGRAM

Date Program Came Into Effect: Organized under the Homes for Special Care Act, 1976

Provincial Authority: Department of Social Services

Objectives: To provide Type I care to those persons who cannot maintain themselves or be maintained in the community.

Scope of Services: There are a number of services provided to residents of "Homes for Special Care" (nursing homes, homes for the aged, residential care facilities). They include:

a) the appointment for every home, of a qualified medical practitioner as a medical health advisor to oversee the organization of medical services and to act on behalf of residents who have no attending physician;
b) the provision of social, educational, vocational, religions and recreational programs and activities in accordance with the interests and abilities of residents;
c) the provision of appropriate and adequate food services;
d) the provision of medical and surgical supplies as required by residents;
e) appropriate management of prescription drug regimens for residents;
f) and the opportunity to work in the home or the community if they are able, however under no circumstances shall a resident be forced to work.

In addition to these general services there are additional services available to residents of residential care facilities. They are as follows:

a) nursing and/or personal care up to 1½ hours per day per resident under the direction of a registered nurse;
b) an annual review of residents' clinical condition.

Eligibility: Selection for a specific level of care is made by a Provincial Classification Committee for those persons either requiring provincial assistance with payment of fees or entering a municipally operated home, with the final decision to admit resting with the home administrator. Criteria used are as follows:

a) the person is physically or mentally handicapped (either mentally retarded or past mentally ill) to such a degree that he/she is unable to function independently or with community support in his/her home;
b) the person is 65 years or older or has been given special admission privilege;
c) the person's primary need shall not be for the level of medical treatment such as is normally provided in hospitals;
d) the person does not require active and continuous in-patient psychiatric treatment;
e) the person is not dangerous to self and/or others and does not behave in a manner which is likely to be constantly disruptive to other residents;
f) the person is stabilized on medications;
g) the person's primary presenting problem is not active involvement in alcohol or drug abuse of any kind for three months prior to admission;
h) the person requires up to 2½ hours per day of skilled nursing and personal care.

Utilization: As of August 1979 there were 24 municipally operated homes with 1 927 beds and 7 private non-profit homes with 1 002 beds. As of December 1982 there are a total of 33 homes for the aged with 3 386 beds.

Fees: Services provided by the homes for the aged are not insured benefits under the Nova Scotia Hospital Insurance Program. Each year the Department of Social Services negotiates with each home for the aged to establish a per diem rate for that home based upon actual costs of providing services. The average per diem rate as of ~~December 1982~~ JAN. 83 is $44.00. The charge to the resident is based upon a means evaluation. A resident may have subsidized all or part of the per diem fee. In those cases where the resident is having some portion or all of the per diem subsidized, the home for the aged bills the municipality for the subsidized amount. The municipality recovers two thirds of this amount from the Department of Social Services.

+6% ←

For those persons requiring assistance with the payment of the fees, they are allowed to retain from their OAS/GIS between $20 to $60 per month as a comforts allowance, depending upon the municipality.

PRINCE EDWARD ISLAND

HOMES FOR THE AGED PROGRAM

Date Program Came Into Effect: 1971

Authorizing Body: Division of Services to the Aging
Social Services Branch,
Department of Health & Social Services

Objectives: The main objectives of the Program are:
- to care for residents of P.E.I. who are 60 years of age or older, who because of physical, emotional, or social dysfunction are unable to remain in their own homes, and whose incapacity does not require the services of an acute care hospital or a psychiatric facility;
- to improve the condition of residents and/or maintain their present level of functioning with a view to returning them to independent living in the community; otherwise to assist them to live out their lives in peace and dignity.

Scope of Services: Services provided by this Program cover Type I through Type III levels of care as defined by the Federal Provincial Working Party on Patient Care Classification. The breakdown of residents receiving care is approximately 23% in Type I, 57% in Type II and 20% in Type III.

Required services include:
- an annual physical examination must be completed for each resident by the attending physician, or by the physician for the Home;
- organized social, physical, recreational and religious activities;
- modified and therapeutic diets;
- approved diet and drug management;
- medical, dental and optical services, prosthetics, hearing aids, clothing (if necessary) and all personal needs;
- physiotherapy may be provided by purchasing these services on a contract basis;
- nursing, personal and supervisory care under the direction of an attending physician or a physician assigned to the Home.

The three Types of care differ in the amount of individual care provided each day:
- Type I - ½ to 1½ hours per person per day
- Type II - 1½ to 2½ hours per person per day
- Type III - more than 2½ hours per person per day

Eligibility: The Program is available to any resident of Prince Edward Island who meets the following conditions:

- has Canadian citizenship or Landed Immigrant Status;
- is over the age of 60 years;
- is no longer able to reside in the community and have his/her medical treatment adequately provided in a general hospital.

Utilization:

	1978-79	1979-80	estimate 1980-81
new admissions	246	228	282

In addition to these admissions the Social Services Branch also provides funding for as many as 286 residents in private licensed proprietary and non-profit facilities. This program was initiated when many residents of these facilities had exhausted their private funding possibilities and were unable to return home.

Fees: Each facility sets its own per diem rate charged to the client for the cost of care provided. In the six Government Operated Nursing Homes the client is charged ~~$47.50~~ 57.00 per day. 1 APR 83

If financially able the resident must assume the full cost of the care. If after assessment by an 'income-needs test' the resident is evaluated to require either partial or full assistance in paying for the cost of care, then the Department of Social Services will assume the deficit.

In the six Private Nursing Homes the province will subsidize the cost of care (at the basic ward rate) of clients for as many as 50% less one of the beds in the facility.

In the two Non-Profit Nursing Homes up to 100% of the beds in each facility may be subsidized by the province.

Funding: The Program is 100% funded by the P.E.I. Department of Health and Social Services, Social Services Branch.

Total Budget:

1979-80	$6,678,100
1980-81	$7,273,400

Out-of-Province Benefits: None

NEWFOUNDLAND

HOME FOR SPECIAL CARE

Date It Came Into Effect: The Homes for Special Care Act came into effect March 1973, although there were Homes for Special Care in existence prior to this date operating under the Welfare Institutions Licensing Act.

Provincial Authority
~~Authorizing Body~~: In 1980 the Program was reorganized and now is administered by the Department of Social Services. The Program was administered by the Department of Health for a brief six month interval in 1979/80, by the Department of Rehabilitation and Recreation from 1973 to 1979, and by the Department of Social Services under the Welfare Institutions Licensing Act before 1973.

However, there are still four homes under the authority of the Department of Health. These four Homes are "Extended Care Facilities" for the most part and have a total of approximately 400 beds.

Objectives: The main objectives of the Program are:

a) To provide a vehicle through which facilities providing services to:
   i) senior citizens and other adults requiring continuing care, receive financial, administrative, and consultative services, and
   ii) senior citizens, mentally and socially handicapped adults receive assessment services to determine their need for institutionalization, and their eligibility for financial assistance to acquire same;
b) To monitor the quality of care being provided in three categories of accommodation: government operated institutions (3); independently managed church/interfaith operated homes (16); and government licensed boarding homes (48).

Scope of Services: There are many services provided to residents of Homes for Special Care, these include:

a) the provision of medical and surgical supplies as required;
b) the appropriate management of prescription drug regimens;
c) the provision of appropriate dietary services;
d) physiotherapy and occupational therapy are available in some facilities;
e) social services in some facilities;
f) a doctor who is on call to all residents (the resident may also use his/her own family physician if desired);

g) nursing and/or personal care up to 3 hours per day per resident under the general direction of a registered nurse.

Facilities are usually designed to cover one type of care, however almost all of them have residents from Type 'O' care through Type III care (as defined by the Federal Provincial Working Party on Patient Care Classification).

Eligibility: A) Private Homes for Special Care (i) Boarding Homes have no formal admission criteria. However, all applicants are required to provide medical and social information to aid the Division of Homes for Special Care's assessment board in determining if person's needs can be best met by a home for special care. Eligibility is determined by an Admission Board. (ii) Church and Interfaith Homes have their own criteria for admission, and they vary with each home.

B) Other Homes for Special Care (i) Government Operated Homes for the Aged have no formal admission criteria. A medical certificate and social information is required in all cases; eligibility is determined by an Admission Board. (ii) Other Homes for Special Care, including Boarding Homes for Ex-Psychiatric Patients have the admission criteria determined by the institution (either the Waterford Hospital or the Western Memorial Regional Hospital).

General eligibility is determined by the person's requirement for the type of services provided by these homes. There are specific requirements for each level of care, but for general admission into the Program the following criteria must be met:

- person is a resident of Newfoundland (exceptions can be made in exceptional circumstances);
- the needs of the person cannot be more effectively met either in their home or as a hospital out-patient.

The following are the criteria for the different levels of care:

Level I: This level of care is that required by a person who is independently ambulatory, but who has decreased physical and/or mental facilities. Therefore, requiring all minimal supervision with activities of daily living.

Criteria: The person

1. will require minimal supervision with bathing, dressing and grooming;
2. will not be socially acceptable in the community and family members are not willing to accept the responsibility for care;

3. may have had psychiatric problems requiring previous admission to institutions and will require constant supervision for behaviour managment;
4. will require social and psychological stimulation.

Level II: This level of car is that which is required by a person who may be ambulatory with or without mechanical aid, i.e. cane, walker, crutches, and who may have decreased mental and/or physical faculties. This person requires "moderate" supervision, but, his/her condition will demand a greater number of care hours.

Criteria: The person

1. may have some loss of hearing and/or vision;
2. will require a moderate amount of assistance with bathing, dressing and toileting;
3. may be unable to communicate some needs;
4. may demonstrate a mild difficulty with orientation or he may have full use of mental function;

Level III: This level of care is that which is required by a person who is confined to bed or can be moved from bed to chair with assistance. This individual requires supervision by various professional workers. The care required for this level includes total assistance for all activities of daily living as well as fulfillment of social needs.

Criteria: The person

1. may require assistance to change position while in bed;
2. may have bowel or bladder incontinence and require indwelling catheter and catheter care;
3. may require daily supervision of surgical dressings, etc.;
4. may present behaviour management problems;
5. may demonstrate varying degrees of difficulty in orientation as to person and place.

Level IV: This level of care is that which is required by two categories of individuals:

- persons who exhibit psycho-geriatric traits;
- persons who, due to congenital or acquired psychiatric problems, exhibit impromptu aggressive and/or hostile violent behaviour.

Criteria: The person

1. will require "continuous" supervision in all activities of daily living;
2. may or may not be independently ambulatory;
3. may or may not have incontinence of bowel or bladder;
4. may demonstrate difficulty in orientation as to time, place and person and tend to wander outside home;
5. may be noisy and disturbing to other residents at night.

Utilization: The following figures do not include admissions to Department of Health homes, or Ex-Psychiatric homes.

	1978/79	1979/80	1980/81
Total admissions to facilities	799	755	507
Total admissions to licensed boarding homes	339	455	335
total	1138	1210	842

Fees: This program is not an insured benefit under the Hospital Insurance Plan. Clients must pay for the services provided on an ability to pay basis. Rates in the Church/Interfaith Homes vary yearly, related to budgetary requirements. The rate in a private Government Licensed Boarding Home is ~~$495.00 per month effective April 1, 1981.~~ 595.00 630.00 / July 83 The resident is allowed ~~$55.00~~ 65.00 per month for personal spending, with the rest of their income going towards meeting their monthly charge. If after assessment by the admission board the person is deemed unable to pay, then the person will receive assistance from the provincial government.

Funding:

Provincial Department of Health	5%
Department of Social Services (Prov.)	95%

Total Budget:

1979/80	$24,300,000
1980/81	$26,571,000

Out-of-Province Benefits: None