Market forces and vulnerable elderly people: Who cares?

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Editorial

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CMAJ 1998;159:151-2

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Most Canadians know about Medicare, our national health insurance plan implemented in 2 stages during the 1960s. Less well known are the major policy changes during the 1960s and 1970s that affected long-term care.

Medicare, based on the principles of shared responsibility and equitable access to health care according to need, won widespread public support. However, the uncontrolled and unregulated expansion of homes for the aged and nursing homes after World War II resulted in disclosures that some facilities were not providing adequate housing, food or care to their residents. One by one the provinces started enacting or amending legislation and enforcing regulations for long-term care facilities. They established licensing requirements, outlined environmental and care standards, and implemented the machinery to monitor adherence.

Provincial governments also recognized the importance of alternatives to acute care, and thus the pace of change quickened. Licensed facilities were provided with grants, per capita subsidies or the co-insurance of facility users, depending on the province. Province-wide home care programs were introduced to permit functionally disabled people with inadequate informal resources to be cared for at home rather than in a facility. Admission to facilities was now restricted to people for whom home care and safety standards could not be met.

In this issue Gina Bravo and her colleagues report on their study in which they assessed the sociodemographic and clinical profiles of a sample of residents in unlicensed homes for the aged in the Eastern Townships of Quebec (page 143). Their findings indicate that the principles underpinning the developments and the advances made in caring for vulnerable elderly people who require institutional care are in danger of being compromised. Unfortunately, it appears that this erosion is not confined to the Eastern Townships or to Quebec. Two concurrent developments within the last 2 decades threaten the equitable distribution of resources for elderly people in institutions. To contain the costs of care in long-term facilities, provinces reduced the bed–patient ratio in licensed facilities (by not building or licensing more beds or by deinsuring lighter levels of care in licensed facilities as the elderly population has grown). Thus, requirements for admission to a licensed facility became stiffer — you had to be sicker and need more services. This led to a substantial increase in the number of people who were not disabled enough to meet the more stringent admission criteria for licensed homes and yet were disabled enough that they could not easily look after themselves at home or did not have relatives nearby who would assume a caregiver function. And so, provinces allowed, and even encouraged, the proliferation of unlicensed homes for the aged, in which the residents pay for their room and board and for some minimal care services. These facilities were supposed to attract paying, functionally independent and healthy elderly people who wanted or needed an environment free of some responsibilities associated with their previous living arrangements. However, it was unrealistic to expect that these residents would retain their ability to function independently over time and that their conditions would not deteriorate.

Therefore, Bravo and colleagues' findings are not surprising. Unlicensed facilities in Quebec are housing and caring for some elderly people who have considerable cognitive and physical deficits, even though Quebec law forbids this.[1] Unli-

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censed homes, predominantly for-profit enterprises, also have fewer and less-qualified staff than licensed long-term care facilities have. Furthermore, for-profit homes have been found to have higher staff turnover rates than non-profit facilities.[2] The findings of Bravo and colleagues surely raise quality-of-care issues.

Governments have a responsibility to ensure that dependent and vulnerable elderly people are not housed in facilities whose living arrangements preclude their receiving a level of care or supervision consonant with their needs. Furthermore, unless the governments assume this responsibility, physicians would be well advised not to direct their elderly patients to such facilities.

The use of the government's regulatory powers is one way of addressing these issues. Regulations governing unlicensed facilities should acknowledge that such facilities, particularly those of medium and large size, will always have some residents whose function is deteriorating or who have bouts of debilitating illness. The regulations should therefore stipulate that an unlicensed facility must have a specified minimum ratio of trained personnel to residents.

In addition, these facilities should not be permitted to keep residents once they require the amount or type of care or supervision that only a licensed facility can provide. The regulations should therefore also state that elderly residents who come to need a specified level of care must be referred for transfer. While they await placement in a licensed facility, the provincial home care program could be called upon to provide additional services and to oversee that their interim needs are met.

Besides ensuring that vulnerable elderly people are in a place where they can receive the appropriate level of care, provincial governments also must ensure that unlicensed facilities adhere to specific building codes and public health and consumer protection standards. Drafting regulations for unlicensed facilities provides a good opportunity to review such questions as the following: Do current building codes specify and enforce appropriate physical environment and safety standards for unlicensed facilities, whose elderly residents may from time to time be incapacitated? What public health standards do these facilities have to meet? How is adherence to these standards monitored? Is the current consumer protection legislation and its monitoring system adequate to protect frail elderly people from possible financial and physical victimization?

This last question is critical because Bravo and colleagues found that almost 40% of the residents in the unlicensed homes they studied had cognitive deficits and that the vast majority had no spouse. Although no data are presented on how many and what type of residents had other family members living nearby, it is likely that there were a number of vulnerable residents with little or no social support to protect their welfare and rights. Even if provinces regulate that some or all of these residents have to be transferred to a licensed facility, unlicensed homes will probably always house some people who are becoming cognitively impaired and therefore more susceptible to victimization.

Provincial governments have allowed the proliferation of unlicensed homes for the aged in order to save money while insisting, with some justification, that their real objective has been to increase the choices for living arrangements offered to elderly people. The study by Bravo and colleagues indicates that the time has come to protect the welfare of vulnerable elderly residents by adopting new regulations for unlicensed facilities and their residents and by reviewing existing regulations to ensure that appropriate building codes and public health and consumer protection standards are met. Otherwise, Canadians are in danger of returning to an era of "horror stories" resulting from an unregulated market.

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