

Editorial: We've Come a Long Way but Are We There?

The two-part article on the development and implementation of a resident classification system for long-term care facilities by Cathy Charles and Corinne Schalm in this issue of the Journal merits special attention. The description of the process and work involved in attempting to develop an equitable funding arrangement for these facilities provides a good example of the contribution applied research can make to public policy. It illustrates the potential of a funding formula for influencing standards of care. It also demonstrates the direction and pace of change in provincial governments' policy towards nursing homes during the last two decades.

The history of nursing homes in Canada is about as old as the country itself, but it has taken a long time for them to get on our health policy agenda. By the 1970s nursing homes had evolved through two phases. The first was the "alms-house" phase, during which benevolent societies and churches cared for chronically-ill, frail and disabled indigent persons who had no informal sources of help. The second was the "Social Allowance" phase during which provincial governments paid for the care of the indigent (cost-shared with the federal government after the enactment of the Canada Assistance plan), leaving other persons to pay for their own care. The only exceptions to this policy were persons in long-term care facilities called hospitals where they did not pay because their care was covered under the 1959 *Hospital Insurance and Diagnostic Service Act*. During this phase, the provinces also instituted or strengthened building and public health regulations governing these facilities.

By and large, the norm for long-term care facilities was then still to provide custodial care. Workers in these facilities were, therefore, generally expected to act as proxies for family members who were not available or were too poor to keep an old, debilitated relative at home. On the other hand, workers caring for persons in the long-term facilities called hospitals (e.g., Ontario's Chronic Care, British Columbia's Extended Care and Alberta's Auxiliary hospitals) were doctors, nurses and para-professionals.

During the 1970s, long-term care facilities entered a third phase during which the care they provided was increasingly medicalized. The impetus for this change was influenced by a number of factors. The respectability, indeed the respect, with which the public regarded hospitals, combined with the generally low regard in which nursing homes were held, suggested to the facilities themselves that professionalization would improve their image and their potential for additional provincial funding. Provincial licensing bodies, and complaints from increasingly powerful organizations of seniors and their families persuaded the provinces of the need to improve care stand-

ards. These pressures reinforced the trend away from custodial care to medical care.

The 1970s also witnessed three other important changes. One was the formalization of categories of institutional care either by licensing specific facilities to provide a particular type of care (e.g., Ontario, Alberta) or by paying facilities on the basis of the levels of care required by the individual in their beds (e.g., Manitoba). Levels of care were generally defined by the amount of nursing care required. The provinces which began paying facilities on the basis of the levels of care required by their residents instituted regular monitoring as the basis for payment. The second change was the initiation or expansion of province-wide community care programs to permit the chronically-ill, the disabled and the frail to remain at home by providing formal services. The third was the implementation of a single-entry system first in Manitoba, then in British Columbia and Quebec, in which the community care programs or the regional organizations in which they functioned became responsible for limiting admission to institutional care to persons who could no longer be safely or economically maintained at home.

In the late 1970s and the early 1980s studies initiated by provinces such as Ontario, Quebec and Alberta showed that categorizing institutions rather than individuals was obscuring the fact that the care requirements of their residents were often more similar than different. This is the context within which Alberta and Quebec began to develop an instrument to measure the level of resource requirements of each facility's residents. The process used to validate the measures and to implement the system with annual monitoring as the basis for the equitable funding of its long-term care facilities as described in the Charles and Schalm papers provides important insights into the complex and exacting scientific and political processes which such an undertaking entails.

The authors also make several important observations about what they learned as a result of their experience in designing and implementing the Alberta measure. In the course of developing the instrument, they found that case-mix indices developed for hospital care and clinical diagnoses were not useful in defining long-term facility resource need but that the levels of dependency and mental impairment, especially when accompanied by disruptive behaviour, were critical factors. Also, the use of the instrument provides Alberta with the ability to measure changes in the case-mix of facilities as it implements its single-entry system and the capacity to identify the costs of these changes over time. (Unfortunately, it does not identify the additional costs which are likely to be incurred by its community care program as it copes with a provincial decision to reduce long-term care bed ratios and sets up a single entry system which will not only increase the proportion of heavy care persons admitted to facilities but will increase the proportion of elderly requiring services at home.) Finally, it provides facilities with standard of care guidelines for persons with differing needs.

Charles and Schalm acknowledge some limitations of the instrument and its use. The measurement of rehabilitation resource needs proved elusive.

Records being kept by each facility for provincial monitoring and payment provide an incentive for the institution to overdocument need. Also, recent trends towards specialized programs will necessitate a clearer definition of core programs to ensure that interfacility comparisons can continue to be made. Despite these limitations, they demonstrate the contribution carefully designed applied research can make to solving practical public policy problems.

Nevertheless, several nagging questions remain: does such an instrument truly reflect the needs of persons who are spending the last years of their life in a nursing home and what kinds of specific tasks are being referred to in estimating direct service needs?

The psychosocial needs of the residents are, by and large, left unacknowledged and unmeasured. This omission ignores and undervalues (by not paying for) residents' need to socialize, to participate in decisions affecting their welfare, to have access to counselling about personal or family problems and to engage in recreational and other chosen activities. While all residents, regardless of their level of dependency, have such needs, this omission is particularly difficult to understand in the case of a province where 20 per cent of the residents are classified as requiring the two lowest levels of care (Advisory Council of Alberta, 1991/92) and are, therefore, likely to be in a facility for very many years (Shapiro & Tate, 1988).

The use of registered nurse (R.N.) equivalence as a basis for payment makes some assumptions which may benefit from being re-examined. One such assumption is that the tasks involved in caring for residents require nursing or para-nursing training. When the most important contributor to institutionalization after age is having no immediate family member on the premises (Branch & Jette, 1982; Shapiro & Tate, 1985) and when most activities of daily living (ADL) tasks, such as help with dressing, grooming, bathing, supervision and even the administration of medication, are usually performed by informal caregivers when an individual lives at home, this assumption may well be unwarranted. While community or institutional workers who perform these tasks need orientation and training, should we be using R.N. (i.e. hospital-type) equivalence or family member equivalence when measuring resource need? Except for residents who require specialized resources, even the heaviest care residents are in this category because their heavy dependency on others is primarily for ADL help or for supervision due to their cognitive impairment. Besides, as the authors themselves pointed out, their instrument does not take account of the need for resources such as rehabilitation services to help individuals achieve their full potential in meeting their own ADL needs.

The use of R.N. equivalence is a feature of nursing homes in the United States and this had an influence on Canadian thinking both directly, as in the case of Alberta, and indirectly. However, nursing homes in the United States provide longer-term rehabilitation which we provide in geriatric or other rehabilitation units and intensive post-hospital convalescent care which we provide in hospital or at home. That is why the average age of ad-

mission to U.S. facilities is about 60 and why a substantial proportion of persons they admit are expected to be there only temporarily before returning home whereas the average age of admission to our nursing homes is over 80, in some provinces about 85, and they generally remain in our facilities until death.

The use of R.N. equivalence also assumes that there is little or no need for workers with other types of training. When, as is now common in those provinces with a single-entry system, a majority of residents are cognitively impaired (sometimes accompanied by erratic or dangerous behaviour) and when others may be suffering from depression or other mental illnesses, should facilities be employing other types of personnel instead of R.N.s or para-professional nurses?

Perhaps the pendulum, impelled by the institutions' drive for respectability and adequate payment and by society's concern for the residents' health and safety, has swung too far from its historical roots which were firmly planted in a social model. As the number of provinces using or experimenting with case-mix indices as a basis for nursing home payment grows, it is important to recognize that such measurements reflect values. It is, therefore, critical for those of us who are engaged in experimenting or refining these instruments to re-examine the premises on which the measurements are constructed. Such a re-examination might benefit from consultation with representatives from those community care programs which place high value on the social as well as the health needs of individuals and their families in assessing the status of the frail, the chronically-ill and the disabled elderly.

References

- Advisory Council for Alberta Fact Sheet. (1991/92). Issue Number 4, Edmonton AB.
- Branch, L.G. & Jette, A.M. (1982). A prospective study of long-term care institutionalization among the aged. *American Journal of Public Health*, 72(12), 1373-1379.
- Shapiro, E. & Tate R. (1985) Predictors of long term care facility use among the elderly. *Canadian Journal on Aging*, 4(1), 11-19.
- Shapiro, E. & Tate, R. (1988). Survival patterns of nursing home admissions and their policy implications. *Canadian Journal of Public Health*, 79, 268-274.

Evelyn Shapiro, *University of Manitoba*