THE DEVELOPMENT OF LONG TERM CARE FOR SENIORS IN NEW BRUNSWICK

When New Brunswick became a separate province with its own government in 1784, social services were provided by families and religious denominations. Two years later the New Brunswick Poor Law was enacted which gave responsibility for assistance and relief for the poor to each local parish. Our current long term care system has its roots in these institutions, provided by parishes to care for the poor and for orphans, seniors and persons with disabilities. With Confederation, the *British North America Act, 1867* gave provinces the exclusive right to legislate on the "establishment, maintenance, and management of hospitals, asylums, charities and charitable institutions." The Province of New Brunswick delegated the responsibility for social welfare services to the municipal and parish councils who financed their services through property taxes.

The provincial government became more involved in the long term care system in the late 1950's, accepting responsibility for the licensing and monitoring of nursing homes and homes for the 'aged and infirm'. In 1961, New Brunswick was the last Canadian province to repeal the Poor Law, replacing it with the Social Assistance Act. This allowed the Province to assume a larger share of the responsibility for the delivery of social services. The Poor Law with its underlying philosophy of the 'deserving' and 'undeserving' poor had served as the foundation for social policy for 175 years.

In the 1960's the long term care system evolved with the addition of regulations for licensing, monitoring and funding of special care homes, the establishment of levels of care and per diems. Government provided financial assistance to persons in special care and nursing homes who were unable to meet the cost of their required care. In 1967, as part of the Equal Opportunity Program, the Social Assistance Act was amended to provide for the centralization of authority for the provision of social services at the provincial level. This would eliminate the disparities in the quality of social services throughout the province caused by differing abilities of parishes and municipalities to finance these services through taxation.

The Province continued to work with special care homes and nursing homes in licensing, inspection and funding matters throughout the 1970's. Subsidies continued to be provided to residents who could not pay for their own care, with per diems being standardized on the basis of the level of care needed. Services for seniors were expanded to promote the well-being of seniors by establishing community-based services as an alternative to institutionalization. A Day Care program for seniors was piloted to test the effectiveness of an alternative to nursing home care for seniors who could live independently with the aid of day time support services. This was followed by the implementation of a pilot project, Community Based Services for Seniors (CBSS), intended to co-ordinate a range of health and social services to keep seniors in their community for as long as possible. Such services included homemaker/ housekeeping, friendly visiting, meals on wheels, day care relief care, protective oversight, buddy system and talent bank. A second goal was to encourage seniors' involvement in their community and the provision of services on a volunteer basis.

Community Based Services for Seniors was expanded in the 1980's to cover the province, with a major emphasis placed on developing a broader range of services in both rural and urban areas, with services included being: homemaker services, senior day care, heavy housecleaning, housekeeper services, friendly visiting, counseling services and telephone reassurance. CBSS services were tailored to the specific needs of the client, and designed to supplement, not replace the seniors' natural support systems. The practice of encouraging clients' financial participation was strengthened by the introduction of a participation fee policy for homemaker, heavy housecleaning and housekeeper services based on the client's income and ability to pay. CBSS services were limited to $400 per month.

By the end of the decade, Government was funding 70% of the operating costs of nursing homes via resident care subsidies. A multidisciplinary review of all seniors on the waiting list for nursing home admittance found that approximately 1/2 could be maintained in their own homes if comprehensive community based support services were available. As it became clear that special care home residents had varying levels of care, special care home rates were differentiated on the basis of the intensity of care required.

A Single Entry Point pilot project for seniors was implemented to test a single entry access model for community long term care and nursing home services, and to determine the effectiveness of a comprehensive array of services to support the frail elderly in their own homes or family type setting to delay placement in nursing homes.

The long term care system matured significantly throughout the 1990's. During the first half of the decade, the Single Entry Point was expanded to include mental health services and to cover the entire province, reducing the nursing home waiting list from 890 to 55 applicants. The SEP demonstrated that it was possible to provide appropriate community care/services to frail seniors within established cost guidelines and at a per diem rate substantially below that of nursing home care. The SEP was gradually replaced by a new Long Term Care Strategy, which provided interdisciplinary assessment and reassessment for the development of co-coordinated and comprehensive service plans. The primary goal was to unit and co-ordinate existing long term care services into an appropriate continuum of care to achieve or maintain the well-being of citizens needing these services. The strategy was to enhance and support the informal system not replace it. Eligibility for service was dependent on an individual's functional ability rather than being targeted specifically to frail seniors or disabled children.

Special care homes were licensed to provide room and board, basic personal care, 24 hour supervision and relief care. Nursing homes were no longer just for seniors but covered all ages and services could be expanded to citizens with physical/mental disabilities, head injuries, dementia, palliative care, etc.

The second half of the 1990's saw the refinement of the long term care system to what is now, for the most part, its current continuum of in-home services, nursing homes, special care homes and community residences. Its goal was to improve or maintain self-care in order to help delay or prevent out-of-home care, with services provided through third party contracts to seniors who needed help with the activities of daily living. The Standard Family Contribution policy was established, identifying family, as opposed to the individual, as responsible for the full cost of non-insured services. The client's obligation to pay took precedence over intergenerational transfers. Government was identified as payer-of-last resort, although subsidies were provided to those who could not pay the total cost of their services. A Single Assessor model was tested whereby one professional staff rather than two conducted the assessment using an automated assessment tool.

A moratorium was placed on the approval of new special care home beds. A new residential model for long term care was implemented based on clients' functional capability, with clients with the lowest level of needs (Levels 1 and 2) receiving services in special care homes and clients with the highest level of needs (Levels 3 and 4) receiving care in either nursing homes or community residences. A few special care homes were authorized to provide services to clients with Level 3 care needs, but who do not require regular nursing care.

In 1999, a review of the Long Term Care Strategy was approved to identify issues of sustainability and responsiveness and to make recommendations for improvement of the strategy. In addition, Government conducted a review of the Level of Care Policy to examine the degree of complexity and the frequency of interventions required by special home residents, and the funding required to provide these residents with adequate services.

The first half of the new millennium saw significant investment in the long term care system. Funding was increased for in-home support to allow an increase in the monthly cost ceiling and to restore the maximum number of hours of home support to 215 hours per month. Funding for wages of home support workers was improved, and per diem rates in special care homes and community residences were increased. Nursing home funding was increased to address resident care needs, work place health and safety issues, and to increase the hours of care. More than $200 million was committed to renovate or replace an ageing nursing home infrastructure, and to increase the number of nursing home beds.

A pilot project to test new ways of delivering long term care services (in home) to adults under 65 was implemented. The moratorium on approval of new special care home beds was lifted where the vacancy rate was lower than 20% or if more beds were needed to provide appropriate residential services to clients.

A number of changes were made to the Standard Family Contribution policy to allow clients and their spouses to keep more of their family assets and income. This included such changes as disregarding Veteran's Pension and the spousal portion when calculating the client contribution for his/her spouse in a nursing home or an approved facility; allowing at least 50% of the family's assets to remain with the spouse at home; exempting the house, cottage, car, woodlot and any kind of real estate; and reducing the period considered for the disposition of assets from 5 to 2 years. The net proceeds from the sale of the family home was also exempted from the calculations.

In the second half of this decade additional changes in the Standard Family Contribution policy have been implemented. Clients in nursing homes, special care homes and community residences who sell their principal residence are no longer be required to increase their financial contribution for their services as a result of the sale. The net proceeds from the sale of the principal residence are exempted when determining the financial contribution of clients. The policy has been converted from a means-based test to an income-based test and nursing home residents are now only required to pay a flat rate of $70 per day to cover room and board. All other nursing home costs are now covered by Government. Residents who cannot pay the $70 per day continue to be subsidized by Government.

In April, 2007 Government announced an initiative to renew long term care with the aim to make the system responsive to the needs of seniors of today and in the future. New Brunswickers will be engaged in the process via extensive stakeholder and public consultations, held throughout the Spring of 2007. These consultations will serve as the basis for developing a renewed long term care strategy which will be phased in over the next 10 years.