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# Self-Managed Care and Individualized Funding: Not the Same Thing!

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# Introduction

It is easy for the labour movement to be suspicious of government initiatives in social programs. Our history has taught us that improvements in social policy have to be won through concerted effort and struggle. This has been why the Canadian labour movement has joined in solidarity with equity and justice seeking organizations to work together for progressive change. Another lesson from this long history is that sometimes there are conflicts and contradictions in the agendas between these different social movements.

Over the past decade we have seen some conflict between the disability rights movement and the labour movement on the question of alternative models of service delivery. In many ways a false antagonism has been created between the right of service-users to direct and manage their own care and workers' rights. On the other hand, as in all such perceived conflicts there is enough of an element of truth to merit discussion. This paper is intended to address the potentially thorny issue of a labour perspective on one increasingly popular alternative model of service delivery - self-managed care.

From the onset it must be established the two pillars on which a labour perspective on the issue must stand:

1. The labour movement's commitment to protect and expand upon workers' rights. This includes the right to organize and collectively bargain and protection from unjust treatment in the workplace.

2. The right of disabled people to be full and active participants in Canadian society. There is a collective responsibility to provide equal access, and the supports necessary to achieve this, to all citizens.

If we work from these two guiding positions we should be able to develop a progressive and positive perspective on alternative models of service delivery. Yes we may hit a few bumps along the way - but the road will get us to where we need to be!

This paper is going to look primarily at the Self-Managed Care/Individualized Funding model of service delivery that is becoming increasingly popular in Canada.

## The Context

There are two main identifiable trends in the development of these programs in Canada. The first is the adoption of neo-liberal policies of fiscal restraint at all levels of government in Canada. Secondly is the growing, in size and influence, of the disability rights movement.

### Government Downsizing

Canada witnessed a major growth in the social services sector in the late 1960s and throughout the 1970s. A key factor resulting in this growth was the introduction of the federal government's Canada Assistance Plan (CAP) in 1966. CAP was a federal/provincial fiscal arrangement whereby the federal government provided provincial governments with fifty cents for every dollar they spent within the social services sector. These 'federal 50¢ dollars' provided provincial governments with a significant incentive to expand social security, services and programs to protect those vulnerable citizens who, through no fault of their own, were not able to fully participate and benefit from economic growth taking place in our country. CAP ensured that the sharing and caring values of Canadians formed a part of our country's overall prosperity. CAP also provided a strong signal that the state had a collective responsibility for the well being of all citizens.

The first years of CAP saw the expansion of social services take place mainly through a centralized delivery system under the direct administration of provincial Ministries of Social Services. In the late 1970s and throughout the 1980s, however, the social safety net showed some signs of stress as governments began to adopt neo-liberal public policies such as wage and price controls through anti-inflation policies, caps on public spending and reductions in corporate taxation. In many provinces, governments continued to fund social services, but downloaded the responsibility for delivery by creating a host of non-profit agencies.

The rate of growth of the social services sector slowed significantly in the 1990s. Provincial governments have been either eliminating, privatizing, and/or downsizing social services. The most significant factor that has led to the contraction of Canada's social safety net was the 1995 federal budget. That budget eliminated the federal CAP program and its 'federal 50¢ dollars' for social services spending, in favour of the Canada Health and Social Transfer (CHST), a federal block funding scheme that greatly reduced federal funding for social services, health care and education.

The result has meant a significant shift in the funding and delivery of social services. In order to cope with the additional burden brought about by the CHST, provinces which have less money for services have begun to restructure their own delivery of social services by downloading the responsibility to municipalities, community-based organizations, the private sector and individuals.

## Disability Rights Movement

Another impetus for the shift of government funding of health care out of more traditional settings into home and self-managed care models has been the rise of the disability rights movement. In particular agitation over the past decades, for de-institutionalization, normalization/community integration, civil rights and independent living has lead to a significant shift in the manner in which services for people with disabilities are conceived.

Historically, the charity model was the primary means by which people with disabilities received support. Inadequately funded and prone to abuses and warehousing charity proved to be a poor model for meeting the needs of these citizens. Responding to pressure from the popular movements, an important component of which were the trade unions, social programs overall shifted more to state-funded and provided services. While never fully sufficient there was at least an acknowledgement that social programs, including those for people with disabilities, were a collective responsibility.

It could be strongly argued that the expansion of the "welfare state" helped facilitate the growth of the contemporary disability rights movement. Improvements in supports provided for people with disabilities meant increased presence in the classroom and workplace. Demands for full and active participation in all areas of public life became a rallying cry for people with disabilities.

The first targets for change were those institutions that isolated and segregated people with disabilities from the broader society. This was also accompanied by a growing recognition of the exploitation and abuse that occasionally occurred in some traditional care settings. People with disabilities were demanding more input and control over the services they needed. It has also been that case that government's have taken advantage of the very real and tangible aspirations of people with disabilities for control over required supports, in their home communities, to engage in an attack on social services. In the majority of cases the shift from an institutional to community based setting was not accompanied by equal and adequate funding. In many cases the marginalized and oppressed conditions of people with disabilities were exacerbated.

The American Independent Living Movement helped to spark a Canadian counterpart in the 1980s. After intensive lobbying they managed to secure stable funding from the state, Human Resources and Development Canada, to establish a network of Independent Living Resource Centres (ILRC) across the country.

# Self-Managed Care Programs

> *"Self-managed care is totally unlike conventional programmed attendant and home care services. All decision-making and most of the administration of self-management is performed by the disabled service-user. This occurs at considerable saving to the skeletal remaining system which, virtually, becomes a*

*monitor/cheque writer; having dispensed with concerns related to items like personnel and contingency management, scheduling, needs assessment and similar kinds of resourcing."*

The above quote expresses the position of many disability rights organizations approach to a self-managed care model of service delivery. Advocates of these types of alternative models of service delivery argue that it provides nothing but benefits to the service-user.

*"Yet without wishing to cast aspersions on those requiring programmed services for whatever reason; with the development of self-managed care systems, we have finally evolved to the point where, from the disabled person's point of view, all vestiges of the medical model of care end, and true person-hood begins.*"

The fundamental arguments used in favour of self-managed care service programs can be grouped as:

**1) Individuals with disabilities (or their guardians) are themselves their best spokespersons**.

Individuals with disabilities have the right to participate in making the decisions that affect their lives. No 'non-disabled' expert or collection thereof can understand the aspirations of a person living with a disability. People with disabilities, and their families, should be able to participate in the planning of services and programs they need and how those services and programs are structured and delivered. Their input can only hasten their eventual integration and full participation in all aspects of society.

**2) The needs of persons with disabilities are not static, and therefore services and programs must be provided based on a 'continuum of care' model.**

From the time they are born through to adulthood, persons with disabilities require a wide variety of different personal services and support programs. These services and programs should evolve along with persons with disabilities, as they themselves develop different interests and goals they would like to achieve, or decide to make changes in their daily lives. These situations also apply to family members and/or support groups caring for an individual with severe developmental and/or physical disabilities.

**3) Quality personal services and support programs must be accessible and readily available in a seamless manner to meet the needs of individuals with disabilities in their communities.**

Basic access to services is often the biggest obstacle to the independence and full participation in all aspects of society for a person living with a disability.

It is important to distinguish between self-managed care and the means by which these services can be offered. The labour movement must support the right for people with disabilities to exercise control over the services they receive. But, the means by which governments can provide these services must be done in a way that respects the rights of both the service-users and the service providers as well as ensuring equality and high standards of care. There are three principle models in which self-managed attendant services could be offered by a province.

The first is an agency-sponsored but user-directed service. Under such a model a central organization would oversee/support the hiring, training, supervision and payment of an employee. The service-user would interview and negotiate a personal support regime with the employee based on their individual needs. A familiar example of this kind of model would be the current practice of forming a relationship with a family physician in Canada. The individual seeking regular medical attention chooses a personal physician from among the number of locally available practitioners. Payment for the service provided is overseen by the provincial government and various regulatory bodies. Province wide standards and fee schedules are established and the physicians have gained, to a large extent, collective bargaining rights. A variation of this model is currently in place in the province of New Brunswick and a number of US jurisdictions.

The second model, the one most often referred to when discussing these types of programs is the individualized funding approach. A more complete discussion of this model constitutes the majority of this paper and follows this section.

The third is a brokerage model involving a middle person acting between the government, which funds the personal programs, services and support, and the individual who receives these personal programs, services and support. The broker doing the purchasing for the clients keeps a fee off the total funding amount. The province of Quebec currently practices a brokerage type of model.

## Individualized/Direct Funding

Most self-managed care programs in Canada are based on an Individualized Funding (IF) relationship between the provincial government and the service user. Individualized funding refers to a transfer of money from governments directly to individuals or their support group for the purchase of personal programs, services and support. The direct dollar model is individualized funding in its purest form. The money goes directly to individuals or their support group, who then purchase the personal programs, services and support. Support groups can include but are not limited to, families, advocacy groups, and micro-boards.

In most programs, the service-user, or their support group, assumes an employer-employee relationship with the attendant. Participants in these programs must recruit, hire, train, supervise and pay, including payroll deductions, their employees. Funding allocations are determined after a needs assessment with the applicant. Usually the

eligible applicant must establish a separate bank account and all the necessary payroll deduction arrangements. As a means to ensure accountability, the province conducts periodic audits of the service-users books.

Other restrictions to the program may apply depending on the province. Most programs prohibit the hiring of family members as attendants. The rationale for the prohibition is to guarantee family members respite from providing personal care. Some concern has been expressed that the hiring of a family member could contribute to the economic exploitation of vulnerable individuals (the statistics of abuse of the elderly and disabled by family members is significant). Both of these are legitimate concerns but most likely the reason is that the total provision of care is extended through the use of unpaid family members, overwhelmingly women, which might not happen when family members are hired.

When IF programs are cited in reports on self-managed care programs the overwhelming justification for these types of funding schemes appears to be perceived cost-savings to the system. Given that the money is provided directly to the service-user to oversee the funds, it is assumed that fewer administrative personnel are required. Similarly, as the individual service-user is in a position to recruit and hire staff it is thought that they will be able to contract for service with employees at a rate of pay lower than that paid in home care agencies. This is achievable only if the individual hired to provide attendant services is not as well trained as other support providers and that established standards of care are not strictly adhered to.

Both of these assumptions should be taken with a grain of salt. Indeed there are some indications that these programs will more likely transfer the administration of employee payment to private sector companies and out of the public service. Most IF programs in Canada provide for, and in many cases actively encourage, the service-user to utilize third party organizations for managing their employees. Also, there is evidence of difficulties in recruiting attendant care workers in all regions of the country based on the low wages and poor benefits these programs offer. It is unlikely given the shortage of home care workers that people will opt for a lower paid self-managed care relationship over a higher paid and protected agency position. As in many aspects of health care market forces prove to be a poor impetus for service provision.

The fact that home care and IF are cheaper for governments to provide is more a consequence of being inadequately funded and not universally available than any real organizational benefits. Were governments to ensure that workers in this part of the health care system received decent wages and benefits and that the services provided were complete and adequate it is unclear whether the savings promised would materialize to the extent suggested. This does not argue against the importance and beneficial nature of home care/self-managed care but rather the motivations of elected governments.

A number of authors point to the differing rates of unionization as a significant determinant in the wage gap between the traditional health care and home care settings.

One of the outcomes of IF schemes, possibly a major motivation for governments, is the virtual denial of organizing and collective bargaining rights for workers.

## Self-Managed Care in Canada

### National Policy Directions

It could be argued that both the provincial and federal governments are showing a renewed interest in implementing policy pertaining to people with disabilities. The 1998 paper by the Federal, Provincial and Territorial Ministers (representing all Canadian jurisdictions with the exception of Quebec) is entitled *In Unison: A Canadian Approach to Disability Issues*. Part of the Social Union initiative (see Appendix I for more on the Social Union) the paper indicates a push by these governments to act on disability issues.

Where the *In Unison* document represents a small step forward is that it recognizes and highlights the unevenness of services provided for people with disabilities. On paper the document was everything that disability activists could have hoped for. But, as in many similar initiatives the mechanisms for implementation were far from clear.

> *"While the spelling out of the situation of Canadians with disabilities that the paper provided, the recommendations it proposed, were everything they could reasonably hope for from a government production. 'In Unison' includes no mechanism tasked for either getting the process underway or keeping its diverse components in some order once it was."*

To date very little has been done with regards to the implementation of the recommendations. Where the report is relevant to the discussion of Individualized Funding schemes is that it does highlight that this may be a viable addition to the range of services provided for persons with disabilities. The theme of "consumer-directed and managed" services is a strong one throughout the paper. There is no doubt that all provinces will be shifting more services for people with disabilities and seniors into a self-managed/IF model.

In addition to provincial efforts the federal government released a draft of its proposed national strategy in January of 1999. Under the working title of "Federal Disability Strategy: Working in Partnership for Full Citizenship", the document was distributed to national organizations representing persons with disabilities for comment and feedback.

The rapid expansion of home care services, of which self-managed care is usually considered a component, has generated a very real need for research and national policy coordination. With federal government announcements of increased funding to health care, a significant portion of which will be allocated for home care programs, there has been a considerable increase of activity in the sector. Health Canada convened a **National Roundtable on Home and Community Care** in February of 1999. The roundtable

was comprised of representatives from a host of organizations with an interest in home care, with the notable exception of the trade union movement. The goal of the meeting was to commence the process of creating a national home care system.

Within many of the provinces a similar process of research and advocacy is gearing up. Again with the promise of increased spending many organizations are scrambling to have input into the manner in which expanded services will be offered. Recently reports on IF were released by the **Ontario Coalition for Individualized Funding** (OCIF) and the **Ontario Federation for Cerebral Palsy** strongly advocating for IF. The report from the OCIF arose from a Roundtable discussion they hosted in May 2000. Again the absence of labour representation is noteworthy.

It is important that the labour movement develop a position on self-managed care and IF as a first step in its efforts to have input into policy formation.

## Programs Across Canada

There are self-managed care programs in most provinces with a fairly limited number of participants. The majority of these programs operate on an IF model of payment. The following is intended to provide a thumbnail sketch of self-managed care programs available with some elaboration where relevant.

### New Brunswick

There is a self-managed care program available in New Brunswick. In 1997-98 there were, approximately, 500 people in self-managed care, the majority of whom are people with disabilities, and for most the Department of Health directly pays for the services. In a small number of cases the service-user pays the entire cost of the service and a few receive a financial allocation from the Department to purchase services related to home support.

### Newfoundland

In December of 1998 the Newfoundland and Labrador House of Assembly passed Bill 56, the *Act Respecting Home Services Provided to Persons in Self-Managed Care*. This legislation established a direct funding program and explicitly stated that people who utilize the program are considered employers of their own workers.

The program implemented in Newfoundland is unique in the broadness of its application. Currently, approximately 80% of people with disabilities use services provided for through self-managed care and only 20% use an agency. A serious concern for both staff and participants in the program is that workers are not covered by workers' compensation. In case of injury the worker may have no recourse but to sue the employer. Apparently the 1997 budget allocated $1 million to extend coverage to these workers but as yet it

hasn't been implemented. Even if implemented the amount established is insufficient to fully cover workers' compensation claims by these workers.

The province of Newfoundland perhaps best exemplifies that home care provision may be increasingly shifted to an IF model. Most provinces with self-managed attendant services apply them to a small segment of the population who requires home care services. Newfoundland has gone one better and is adopting it as a model for all home care services - from support to seniors to persons with disabilities. This has been quite a fractious dispute in the province, including a supreme court challenge, and has led to the de-unionization of home support workers.

### Nova Scotia

In 1994, Halifax's Metro Resource Centre for Independent Living Resource initiated a self-managed care pilot program. Following the pilot project the Metro Resource Centre submitted a proposal to increase the service province-wide between 1998 and 2003. Over these five years the program will be introduced in Nova Scotia's four health regions with the goal of adding 200 additional service-users by 2003.

### Prince Edward Island

While not formally available in PEI there are a small number of individuals, less than five, involved in self-managed care as part of a pilot project.

### Quebec

A self-managed care program has been in effect in Quebec for a number of years. Eligible participants are responsible for recruiting, hiring and supervising attendants, but the funds are not directly provided to the service-user. Instead the Centre Locale de Services Communautaires (CLSC) informs the Employment Service Cheque (ESC) Processing Centre of the need to pay the attendant. The service-user then completes a record of hours worked to submit to the ESC.

While the program is available to seniors the majority of users are people with disabilities, as is the case in all provinces. In 1997-98 there were approximately 6,000 people using this service.

### Ontario

Ontario has what is probably the most comprehensive of the self-managed care programs in Canada. After a 1994 pilot project the provincial government announced that it could serve as a possible model for self-managed care (direct funding) of attendant services. In the program the province provided funds to persons with disabilities to hire, train, supervise and pay for their own attendants. In July of 1998 the program was declared a success and the provincial government made it a permanent program and announced

expansion. During the 1997-98 year there were 102 participants in the program, almost all persons with disabilities.

### Manitoba

In 1994, following a two-year pilot project (1991-93), the government of Manitoba expanded its self-managed care program across the province. The Self-Managed Care Option is operated through the provincial Home Care program. Eligible individuals receive direct funding to make arrangements for their assessed needs. The service-user is considered the employer in the relationship.

Most researchers on the topic acknowledge that the 1996 strike by home care workers in the province contributed to an increased emphasis on the program by the previous government. Reports suggest that the current government is re-examining the provision of home care in the province.

### Saskatchewan

There is a self-managed care program being designed in Saskatchewan but not, as yet, implemented. One Health District does offer a self-managed care option to its home care service-users of which there are less than five participants, all of whom are persons with disabilities.

### Alberta

The Alberta Home Care Program implemented a self-managed care option in 1993. It followed a two-year pilot project, 1991-93, as a response to growing demand from consumer organizations and disability rights groups. Between 1997 and 1998 approximately 1,130 people participated in self-managed care, the majority of whom were people with disabilities (the program is open to seniors and others but these appear to constitute a minority of service users).

It is a true IF program as eligible service-users receive a monthly transfer of funds with which to pay their attendants. The service-user is considered the employer and must pay all payroll deductions, train and manage their employee. Under the program the service-user may purchase administration services from an agency.

### British Columbia

British Columbia's Regional and Community Health Authorities offers a self-managed care program through its Choice for Supports in Independent Living option. The program was embarked upon in 1994 to provide personal care and home support to persons with severe disabilities living in the community. Funds are provided directly to eligible individuals who then recruit, hire, train and pay their attendants.

There are about 300 individuals participating in the program, the majority of whom are people with disabilities.

### Northwest Territories

Currently self-managed care is not available in the Northwest Territories.

### Yukon

Currently self-managed care is not available in the Yukon.

## Evaluation of Self-Managed Care Programs

The conclusions reached on self-managed attendant service programs most often depends on the perspective taken by the researcher conducting the report. Most advocacy organizations for people with disabilities report that this form of program is highly effective. Studies have tended to be case studies utilizing anecdotal evidence and may be biased to reporting favourable accounts. Having said that, the bulk of evidence seems to suggest that users of self-managed attendant services are happier with this arrangement than past agency-based models.

There is very little research done focusing on the experiences of the workers in the system. The evidence that does exist tends to be less enthusiastic, though not entirely hostile, about working directly for an individual employer. Almost universal is the concern about low wages, poor working conditions, and the quality and consistency of service providers.

It is important to remind the reader that self-managed care and IF are not necessarily connected. As has been previously mentioned there are other possible models of funding self-managed care programs. That IF is the most common model of providing these programs in Canada reflects political priorities of various levels of government and not best practice decisions.

When looked at as a body a number of topics arise both in favour of self-managed care/IF and in criticism.

### Strengths of the programs:

- Improved individual choice and control.
- Flexibility of services provided.
- Enabling individuals to be more independent and autonomous.
- Client satisfaction.

**Difficulties with the programs:**

## Workplace Issues

- The rates of pay and conditions of employment show no uniformity or consistency within jurisdictions, indeed sometimes between service-users. While there is some evidence in a few jurisdictions that workers in self-managed care programs have slightly higher income than their agency home care worker counterparts this is only comparing bad pay with worse. The wages paid to attendants is still considerably lower than that paid to workers in traditional health care settings. This is largely a result of the constraints placed on funding than anti-worker attitudes held by the service-user.

- In some instances, unreasonable expectations are placed on workers.

- There is evidence of the denial of employment standard provisions to workers primarily as a result of lack of knowledge of the employer. For example, in Newfoundland there was recent evidence of a worker not being paid for statutory holidays.

- Many home care workers are individuals who previously worked in the more traditional health care sector. This is undoubtedly true for self-managed care attendants. Overwhelmingly these individuals report a decline in salary and working conditions when moving into these programs.

- Often workers in self-managed care programs are themselves vulnerable people subject to abuse and exploitation.

- There are serious concerns about the health and safety of attendants. Often inadequately trained and working alone they are highly likely to injure themselves doing heavy lifting or using equipment. In some jurisdictions they are not covered by worker's compensation.

## Problems for the Service-User

- The level of training for self-managed care providers under IF is usually considerably lower than for agency based workers resulting in a lowering in the quality of care. Furthermore, in the absence of established standards of care there is no collective recognition of best practices in the provision of support.

- The turnover rate for workers is high. Often trained employees will opt to work in better paying agencies or in more secure settings. This has meant that the process of recruitment, hiring and training of personnel has to be an ongoing process. Recent reports favouring IF have advocated the creation of support

services to assist people with disabilities with these roles. This would seem to beg the question why replace existing agencies with new ones?

- In smaller rural, northern and remote communities the availability of funding does not necessarily mean that there are potential workers.

- Increased responsibility of recruiting, hiring, supervising and administering the program. While many said that the benefits outweighed this problem the repeated references to these concerns indicates that it is not an insignificant issue for the user.

- Lack of back-up services.

- As the service-user must provide training for their attendant a number of studies have highlighted the lack of adequate education as a problem.

## Conclusion

It is a reflection of the current policy directions being adopted in this country that IF is becoming the dominant funding model for self-managed care programs. Neo-liberal policy analysts and right-wing political parties have been strongly advocating similar programs in almost all areas of public policy. For example, the voucher system in education, replacing the CPP with an RRSP scheme, and individualized subsidies in childcare. The goal is to replace a pre-existing system of service delivery, in this case the health/home care system, with individual purchasers of service. This does not negate the potential benefits of self-managed care but should raise alarm bells for all of us who value a healthy and vibrant public sector.

The predominant theme of this paper is that self-managed care and IF are not the same thing. When you examine the strengths attributed to self-managed care the list does not immediately suggest that service-users must assume an employer relationship with their attendant. Indeed there are indications that people find the bureaucratic elements of the program an obstacle to overcome. This is not entirely surprising. For the overwhelming majority of people full citizenship and societal participation is not dependent on being able to hire, supervise and pay employees. Also, the employee-employer relationship is always a slightly antagonistic one and it is naïve to think that it would not be the case for persons with disabilities in an IF relationship with their personal support staff.

Claims that self-managed care and IF represent a paradigm shift in the provision of personal supports to people with disabilities are very much overstatements of the facts. The paradigmatic shift in health care provision is the move from the hospital setting to the community. Moving from a medical model of diagnosis and treatment of people with disabilities to one of providing self-managed community support has been a considerable step forward in respecting human rights. Individualized funding is simply reintroducing market considerations into the system. It is not that long ago when people with disabilities, who could afford to do so, hired personal servants. In fact, if a paradigmatic shift is coming, it is hoped that it would be one where the rights and needs of the attendants were also entered into the consideration!

It is quite easy to envision alternate models of funding self-managed care programs. One that was mentioned earlier is similar to that which most people utilize to form a relationship with a family physician. Under a model of this type:

- A roster of qualified individuals authorized to provide attendant care for a region could be established.
- Standards of care could be set and enforced by regulatory bodies.
- A high level of initial training and skills development could be assured the individual service-user prior to the more individual specific orientation.

- Workers rights to collectively organize and bargain would be provided for.
- Province-wide rates of pay and benefits would be established and enforced.
- The burden of recruiting, hiring, managing, and paying (including associated payroll obligations, is removed from the individual.
- The provision of services for people with disabilities remains a collective obligation for society and not an individualized market relationship.

A model of this type, it is believed, provides for all the benefits of self-managed care without the problems associated with Individualized Funding.

# Appendix I

## The Social Union

The debate about Canada's Social Union refers to the distribution of powers, responsibilities and resources between the federal and provincial Governments. Following the establishment of the CHST the provinces met with the purpose of hammering out a new arrangement between themselves and Ottawa.

The provinces motivations for the Social Union talks are quite easy to see. While the five principles of the *Canada Health Act* were retained in the CHST, and two new standards were added (no user fees or extra billing) only the federal Government can judge whether a province is complying with these national standards. Dramatically reduced funding made it far more difficult for provincial Governments to deliver programs as they were in the past. The provinces were irritated that the federal Government was giving them so much less, while binding them to national standards and retaining the exclusive right to police the system.

At the beginning of the Social Union debate, the provinces wanted the federal Government to be barred from introducing new national programs without provincial approval. They wanted an end to the right of the federal Government to decide whether provincial spending, on health care especially, was living up to national requirements. The provincial Governments also wanted an assurance that federal transfers would not be cut unilaterally.

When the talks appeared to be going nowhere, the federal Government simply purchased the Social Union agreement to the tune of $3.5 million per province in the form of a trust fund for health care.

On February 4th, 1999 the agreement was reached without any public consultation and without approval by Parliament, or any of the provincial legislatures. The Social Union framework is still unclear on a number of issues. The agreement stipulates that it will promote equality of opportunity for all Canadians, however there is no mention on how this will be achieved. The five principles of Medicare are mentioned but the new principles under the CHST, namely no user fees and no extra billing are not referred to. The deal also talks about "monitoring outcomes of social programs and reporting to constituencies on the performance of these programs", but is very vague as to what that means.

The $3.5 million trust fund that was referred to earlier in the report is a one-time supplement to the CHST. In effect, it was a bonus for signing the Social Union framework. This money will be put into a trust fund for the provinces to draw on over three years, although if they choose they can take all the money in year one.

However, under the CHST, the federal Government can no longer ensure that the provinces will actually spend these funds on health care. Consequently, the provincial Premiers stated, by way of letters, that they would spend the money exclusively on health care.

Community-based services such as home care are not included in the *Canada Health Act*. Hence, the CHST money and the $3.5 million trust fund are not going towards these types of services. This is unfortunate because the point of entry into the health care system in Canada is increasingly community-based rather than institution-based.

In every province, there has been a decentralization or regionalization of services. If Governments wish to put the health care system back on its feet, they need to look at a new foundation for the proposed system, and where they want to go with it, rather than come up with band-aid solutions tailored for the old structure.

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