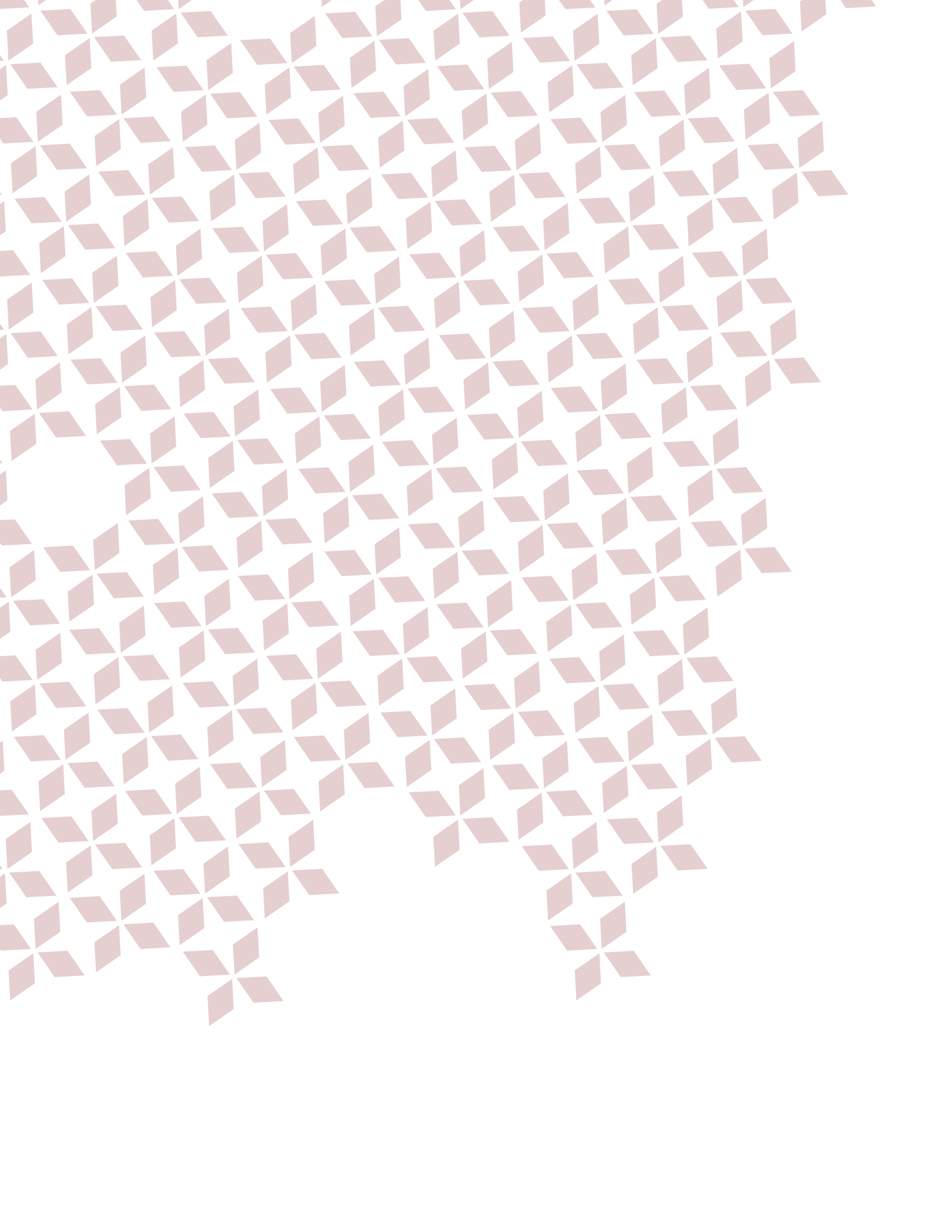




**RENEWING CANADA'S
SOCIAL ARCHITECTURE**

DISABILITY SUPPORTS: MISSING ON THE POLICY RADAR

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PROBLEM STATEMENT

Disability supports comprise a crucial but sorely neglected area of Canadian public policy. Quality health care always ranks near the top of the issues that matter to Canadians. Supports for persons with disabilities, by contrast, rarely figure prominently on any policy radar screen. In fact, they never seem to make any list despite their importance to us all.

POLICY OBJECTIVE

The objective of the policy options proposed in this paper is to enhance both the supply and quality of disability supports throughout the country.

CURRENT STATUS

Disability supports refer to the goods and services that enable people to live independently in communities and help them stay out of hospitals, group homes and long-term care institutions.¹ These supports are considered essential to the 3.8 million Canadians — close to 14 percent of the adult population — formally identified in 2012 as limited in their daily activities due to a disability [Statistics Canada 2013].

But disability supports are relevant to far more than this designated population. They also provide crucial assistance to hundreds of thousands of elderly individuals not formally classified as having a disability. This is potentially a very large group. Canada is aging rapidly; 25 percent of the population will be over age 65 by 2030.

While many Canadians remain active and healthy well into their senior years, the incidence of disability rises with age:

... 2.3 million working-age Canadians (15 to 64), or 10.1 percent, reported having a disability in 2012, compared to 33.2 percent of Canadian seniors – those ages 65 or older. Within the working-age population, those reporting a disability was 4.4 percent for people ages 15 to 24; 6.5 percent for those 25 to 44; and 16.1 percent for those 45 to 64. This proportion reaches 26.3 percent for those ages 65 to 74 and 42.5 percent among those 75 and older [Statistics Canada 2013].

Disability supports comprise a vital component of the community care system that enables elderly Canadians to live at home for longer periods and out of residential facilities, if they choose. These goods and services can also relieve heavy pressures and costs on the formal health care system. While disability supports are essential to ensuring a good quality of life for persons with disabilities, they represent a public issue relevant to the entire population.

This paper presents several policy options for improving both the quality and quantity of disability supports. It is of interest that several nations, including the United Kingdom, Australia and New Zealand, have formulated long-term disability strategies. These involve a set of linked measures that fall within the purview of different government departments. Canada might consider a similar approach in order to coordinate the myriad actions required for the more effective provision of disability supports.

DRIVERS OF CHANGE

In March 2010, Canada ratified the UN *Convention on the Rights of Persons with Disabilities*, which requires signatory governments to work toward the full participation of these individuals. Canada's aging population is another factor that will drive the demand for disability supports. In the meantime, the many shortcomings within the current system are fuelling efforts to introduce substantial improvements.

While there appear at first glance to be many avenues for accessing disability supports, the current system is plagued by myriad problems. Many Canadians who need assistance to live independently or who want to participate in education, training or employment are unable to do so because they have limited access to these supports. The main problems relate to availability, affordability and responsiveness, discussed below.

AVAILABILITY

The availability of disability supports varies widely throughout the country. The current system — such as it is — defies simple description. It is a hodgepodge of public and private arrangements. Moreover, the supports that may be provided in one jurisdiction may not exist elsewhere. Availability problems are particularly acute in rural and northern regions of the country. Disability supports and services may be available at very high cost or not at all.

The delivery of technical aids and equipment illustrates both the complexities and inequities in the system. Patients in hospitals or nursing homes generally receive the aids and equipment they need as part of their health care treatment. Access is more complex for individuals living independently in the community.

Ministries of education or health usually assume the cost of technical aids and equipment for children in public schools. Adults gain access to technical aids and equipment through different routes, depending on the jurisdiction in which they live, the nature of their disability and the types of income security or training programs with which they may be involved. Geography and jurisdiction play important roles in determining access to disability supports.

Students pursuing post-secondary education may access these supports directly through their college or university, or indirectly through student grants. Individuals participating in some form of rehabilitation funded by a disability-related income program, such as Workers' Compensation, may receive assistive devices or special equipment as part of that program. Individuals not involved in rehabilitation or training (e.g., they may be seeking work or at home) generally must make provision for special needs on their own.

Some provinces operate specific programs that provide technical aids and equipment. Alberta Aids to Daily Living, for example, helps individuals with a chronic disability or illness gain access to medical supplies and equipment required for independent living at home. The Saskatchewan Aids for Independent Living Program and the Assistive Devices Program in Ontario also make available a range of technical aids for those who qualify on the basis of the program criteria. There is a sliding scale fee structure.

In other jurisdictions, selected programs offer only certain types of equipment such as hearing aids, respiratory machines or wheelchairs. Alternatively, the equipment may be made available only to persons with designated conditions such as paralysis, cancer, cystic fibrosis or kidney failure.

The provision of personal services is equally complex. While provinces and territories (municipalities in some jurisdictions) generally are responsible for financing these supports, not-for-profit organizations and small private companies typically deliver the services. User fees may be charged to offset the associated costs.

Services that are primarily health-related tend to be furnished through various health settings. By contrast, supports that tend to be more social in nature, such as homemaker services, generally are paid for by ministries of social services and are delivered by not-for-profit organizations. Sometimes it is not easy, however, to distinguish between health and social services. Attendant services are an example of a personal support that combines both components.

Finally, ministries of education are involved in most jurisdictions in the provision of supports required for educational purposes. But these same supports may not be available once a child leaves the school premises. An attendant who assists in the classroom may not be provided, for instance, to help a child participate in a recreational program in the community. Parents may have to pay privately for this service or seek assistance from a local organization, such as a service club.

There are clearly many entry points into the disability supports maze, each with its own unique eligibility criteria. In order to access a program or service, applicants typically have to tell their story to several different people to receive

what they require at a particular time. Inordinate resources tend to be spent on multiple assessments. Sometimes there are such lengthy delays in service provision that circumstances change significantly from the initial contact. The assessment process then begins all over again.

Unfortunately, there are no comparable pan-Canadian data that exist on current expenditures on disability supports. The problem arises from the fact that the unique functional arrangement and delivery mechanisms make it impossible to present a cross-jurisdictional comparison.

The national coalition Every Canadian Counts, which is advocating a pan-Canadian disability supports insurance plan, made the cost challenge somewhat more manageable by carrying out a study of the expenditure on disability supports for one group only (i.e., persons with developmental disabilities). Eight jurisdictions reported the following expenditures in 2013 (2012 for Québec) [Every Canadian Counts 2014]:

BRITISH COLUMBIA:	\$727 MILLION
ALBERTA:	\$825 MILLION
SASKATCHEWAN:	\$330 MILLION
MANITOBA:	\$496 MILLION
ONTARIO:	\$1.7 BILLION
QUEBEC:	\$869 MILLION
NEW BRUNSWICK:	\$341 MILLION
NOVA SCOTIA:	\$945 MILLION

In fact, the group itself includes a caveat with its figures:

You'll notice a lot of information is not available, and the data we did find is not very reliable. This is representative of the state of data collection across the entire disability supports system in Canada [Every Canadian Counts 2014].

AFFORDABILITY

Affordability is another serious problem when it comes to disability supports. While costs vary by type and extent of the goods and services that a given individual requires, they can range in the hundreds or even thousands of dollars a year. Often only limited financial assistance is available to offset these costs.

As noted, provinces and territories may deliver disability-related services directly and/or purchase them from not-for-profit agencies and private

businesses. The cost of services that relate primarily to health care are typically covered fully or partly by medicare. The provision of disability supports that are not deemed 'medically necessary' usually involves a user fee, which varies by level of household income. Beneficiaries of certain income security programs, such as social assistance or the Guaranteed Income Supplement for seniors, may be eligible for disability supports at little or no personal cost because they already qualify as a low-income household.

The federal Medical Expense Tax Credit reduces the cost of a designated list of disability supports. Only expenses in excess of \$2,208 for 2015 or 3 percent of net income (whichever is lower) can be claimed for this non-refundable tax credit. Because the credit may be claimed for health-related expenses, it is available to all Canadians and not just to persons with disabilities. The Disability Tax Credit also provides some tax relief for the additional hidden costs associated with disability, such as laundry expenses or the purchase of specially designed clothing.

But non-refundable tax credits have serious limitations. Their main shortcoming is that they are of little value to modest- and low-income households, which pay little or no income tax and therefore cannot benefit from a tax reduction. While non-refundable credits reduce income tax payable for eligible taxfilers, they do not provide any assistance to offset the original purchase price.

Canadians with little or no income or those who cannot afford to pay for high health-related costs often turn to social assistance (i.e., welfare) in their respective jurisdictions. Applicants' assets must also fall below designated levels in order to qualify for this income program [Tweddle, Battle and Torjman 2014]. The primary role of welfare is to provide financial aid for basic needs — food, clothing, shelter and utilities. But the program may also pay for additional items, such as wheelchairs, hearing aids, prosthetic equipment, medications, special eyeglasses or other assistive devices, arising from a health-related or disabling condition.

There are considerable limitations to welfare, however, in that certain goods may not qualify as special assistance items. There are also fiscal limits. If a province or territory has exceeded its special needs allocation prior to the end of the fiscal year, it may simply stop paying for special assistance items until the start of the next budget cycle.

Unfortunately, these special needs provisions can create a 'Catch-22' for social assistance recipients. The availability of this form of income-in-kind makes it difficult to move off the program for fear of losing essential disability supports. It may be better to stay on welfare than to find low-paying, typically precarious employment without benefits that does not cover these additional costs.

Ideally, disability supports would be available through a provincial or territorial system that is responsive to changing individual needs through the lifespan.

RESPONSIVENESS

Even when disability supports are available or affordable, problems may arise around their responsiveness. Technical aids, equipment and services for persons with disabilities must be highly individualized. Each person requires a unique set of supports.

But the needs of the individual may not line up with the eligibility criteria of the available program. In Saskatchewan, for example, a person must be paralyzed in order to be eligible for a wheelchair under the Paraplegia program. Someone with a condition causing similar functional ability, such as osteoporosis, would not qualify for this assistance.

Disability supports are often not available at the place they are required. While some services may be provided to individuals in their homes, these may not be delivered in settings such as schools, workplaces or recreation centres. Certain services operate as though they are needed only between Monday and Friday, 9:00 am to 5:00 pm, leaving individuals to make private arrangements in the evenings and on weekends.

Consumers generally have little say in how disability supports are organized, delivered or managed. Consumers of disability supports will often report in personal interviews or in group meetings that they are afraid to voice their concerns for fear of personal reprisal or losing the service altogether. They would rather stick with something that is modestly adequate than end up with nothing at all.

Finally, cultural sensitivity has become a growing concern, particularly in relation to the delivery of personal services at home. But it is often difficult to respect these preferences because of the myriad staffing challenges that local agencies currently face.

COMPARATIVE CASE STUDIES

Recommendations and policy options related to enhancing the responsiveness and supply of disability supports are presented in the next sections. The discussion makes clear that there is no single one-size-fits-all appropriate policy measure. Rather, a cluster of linked actions is both possible and desirable.

In recognition of the need for a set of cohesive policy measures, several countries have introduced national disability strategies, which act as a policy ‘umbrella’ to coordinate the individual measures that comprise this policy domain. The federal governments of the United Kingdom, Australia and New Zealand, for example, have enhanced the participation of persons with disabilities and the provision of disability supports through their respective national strategies.

In the United Kingdom, the Office for Disability Issues has published *Fulfilling Potential*, which acts as its guide for improving the lives of persons with disabilities. The framework sets out the component of its “personalisation agenda,” discussed below.

In 2010, Australia introduced a ten-year National Disability Strategy that commits all governments to a national approach to help persons with disabilities maximize their potential and participate as equal citizens in Australian society. The development of this National Disability Strategy is the first time in Australia’s history that all governments have committed to a unified, national approach to improving the lives of people with disabilities, their families and carers, and to providing leadership for community-wide shifts in attitudes.

New Zealand’s disability strategy was developed in 2000. It identifies 15 key objectives and a set of associated actions to enhance the participation of persons with disabilities, starting with both greater recognition of their needs and widespread attitudinal change. The strategy also includes a distinct set of policy proposals related to the needs of the Maori population.

In Canada, several provinces have introduced relevant disability-related strategies. The goal of the Disability Strategy in Saskatchewan is to create a more responsive, accessible and inclusive province for persons with disabilities. This was a positive announcement, given the problems that had been identified

in some of its programs. Proposed changes will be organized on the basis of priority areas highlighted in the *Saskatchewan Plan for Growth* — notably housing, transportation, employment, education, supports for caregivers and community inclusion. The Strategy may include additional priorities identified through a public consultation process.

Ontario and British Columbia have undertaken extensive province-wide processes to make their respective jurisdictions more accessible and inclusive for persons with disabilities. These efforts serve as umbrella frameworks for a set of linked policy measures.

Moreover, in its Strategic Plan 2011/12-2013/14, BC had identified five Great Goals that it sought to achieve for a Golden Decade. Great Goal #3 was to build the best system of support in Canada for persons with disabilities, those with special needs, children at risk and seniors. In order to achieve this goal, the Ministry of Health and Social Development collaborated with other ministries to develop and champion measures to improve accessibility and inclusion for persons with disabilities. The current Ministry of Social Development and Social Innovation continues to pursue these objectives.

In Canada, provinces and territories are the primary delivery agencies when it comes to disability supports. However, the federal government can play a vital leadership role and make important funding contributions.

POLICY OPTIONS

Resolution of the myriad problems related to the availability, affordability and responsiveness of disability supports requires a set of actions that can be grouped into two main streams of intervention. These involve improving the provision of disability supports and expanding their supply. Both areas are discussed more fully below.

I. IMPROVING THE PROVISION OF DISABILITY SUPPORTS

There are several policy measures that would improve the availability, affordability and responsiveness of disability supports. One route involves incremental improvements to the current system by enhancing the quality of existing programs and services.

A. MODIFYING THE GOVERNANCE OF DISABILITY-RELATED PROGRAMS

The Caledon Institute set out a detailed set of steps for these improvements in the report *Five-Point Plan for Reforming Disability Supports* [Torjman 2007]. A key first step would be to engage consumers in the governance of disability-related programs and services in order to ensure their appropriateness and responsiveness. The consolidation of some programs as well as the provision of navigation or brokerage services would also ease access to the complex world of disability supports.

B. SHIFTING TO INDIVIDUALIZED FUNDING

Another remedy to the access problem is to boost the incomes of persons with disabilities to enable them to purchase the supports they require. The problem with this approach is that needs are so highly individualized that some people may need relatively small amounts of cash to buy their respective disability supports while others may require substantial sums. A standard across-the-board increase would be a welcome measure when it comes to purchasing basics, such as food, clothing and utilities, but is not the most appropriate approach with respect to personalized disability supports.

One way to address the need for personalization is through a payment method known as individualized funding, which involves the provision of dollars directly

to individuals. This form of funding is an arrangement in which a designated amount is paid to individuals on the basis of a comprehensive needs assessment. But individualized funding is not simply a transfer of dollars to allow consumers greater choice among existing options. It represents a form of purchasing power that can play a vital role in generating a greater supply of supports.

Several provinces employ individualized funding for certain programs (e.g., home care in Manitoba). The Special Services at Home program in Ontario provides individualized dollars to families caring at home for a child with a developmental or physical disability. Alberta and British Columbia also use individualized funding for a range of disability-related programs.

The UK has introduced the Personalisation Agenda initiative that aims to give individuals choice and control over how their needs are met. Under this approach, consumers are actively involved in producing a support plan, which takes into account not only health but also personal, family, social, economic, educational, mental health, ethnic and cultural background and circumstances. The plan is paid for by direct payments or through the provision of appropriate goods and services.

Australia is another country that has seen growing support for individualized and self-managed funding with a full range of choices within the service system. New Zealand also employs individualized funding to enable the development of a holistic approach to assessment and service provision that applies across agencies and funding sources.

Despite the many advantages of individualized funding, there are several potential problems in the arrangement. There are limits to what it can achieve, especially in the short term. It may not produce new supports right away or in sufficient numbers. Accessible housing with associated services, for example, will not spring up immediately simply because certain individuals happen to have the money to purchase it. There may be a time lag between demand and supply. In addition, some consumers find the self-management of their services to be a stressful challenge.

C. ENHANCING FINANCIAL ASSISTANCE DELIVERED THROUGH THE TAX SYSTEM

A third policy action involves improving various tax measures in order to reduce the cost of disability supports. One way to redress the current weaknesses earlier discussed is to make the existing Medical Expense Tax Credit and Disability Tax Credit fully or partially refundable in order to provide some financial assistance to lower-income individuals who do not pay income tax. This option would be costly for governments because refundability would extend this tax assistance to the entire population.

But these options — improving the quality and responsiveness of existing services, individualizing the provision of disability supports and enhancing the ability to purchase disability-related goods and services — do relatively little to expand the supply of available supports. An explicit focus on the expansion of supply is required.

II. EXPANDING THE SUPPLY OF DISABILITY SUPPORTS

The existing network of personal supports must not only be improved, but must also be expanded because it is inadequate in meeting the range of circumstances of persons with disabilities. Nor will these options be sufficient to respond to the growing needs of an aging population. With respect to home care, for example:

... the data show that 2.2 million Canadians receive home care — 8 percent of the population over the age of 15. Most care recipients are frail seniors with chronic health conditions, but there are also many people with physical, developmental and psychiatric disabilities. About one in seven people — 331,000 people — who got home care in 2012 did not receive all the care they needed; their needs were only partially met. Another 461,000 chronically ill Canadians needed help with daily activities but did not receive any home care at all. Without a doubt, these numbers underestimate the real needs. Statcan surveys do not reach people living in nursing homes and hospitals — and many of them could be living at home with the proper support [Picard 2014].

In most provinces, public programs are not keeping pace. Only about 4 percent of public health spending — an annual \$6 billion — is going toward home care [Picard 2014]. The following proposals move beyond the existing system in order to enable a significant expansion in the supply of disability supports.

A. DISABILITY SUPPORTS FUND

Governments can enhance the availability of disability supports through direct investment in their supply. One option is to create a new Disability Supports Fund that would harness federal and provincial/territorial investment in these goods and services.

The federal dollars would lever matched or greater provincial/territorial contributions. While governments would be the primary funders of disability supports, the disability community in each jurisdiction would be actively involved in decisions regarding their design, delivery and governance. In order to ensure adequate investment as well as stability in this financing arrangement, the Disability Supports Fund could be implemented through a multi-year schedule of funding and continual assessment.

The proposed financing arrangement would allow flexibility in provincial/territorial design and delivery. But in order to receive federal funds, provinces and territories would be required to adhere to a set of guiding principles.² The *Canada Health Act* represents a policy precedent for this approach.

A major strength of this proposal is that a Disability Supports Fund would establish a national mechanism to enable the provision of disability supports that would be completely separate from income security programs. It no longer would be necessary for persons with disabilities to rely on a given income program, such as welfare, in order to obtain essential supports. Ideally, the integration of disparate programs and services would also reduce the barriers created by current funding arrangements, which basically make artificial distinctions among health, social and educational services.

The Caledon Institute of Social Policy put forward this proposal in 2000. At the time, the disability supports were referred to as ‘personal supports’ in recognition of the fact that the proposal was intended to meet the needs not only of persons with disabilities but of all Canadians, especially in the content of an aging population. The report noted that an adequate supply of personal supports would help fill a major gap in community options of independent living that is creating huge pressures for costly hospital-based care [Torjman 2000].

This proposal would be a form of multilateral federalism involving federal and provincial/territorial collaboration. Unlike the current political climate, there used to be real opportunities in the country for this type of bold approach. On October 27, 1998, all governments except Quebec signed a pan-Canadian agreement on disability entitled *In Unison: A Canadian Approach to Disability Issues*. *In Unison* committed all governments to work together toward ensuring access to disability supports, decent employment and adequate income [Federal-Provincial/Territorial Ministers 1998].

B. BASIC INCOME/DISABILITY SUPPORTS REINVESTMENT

Another policy option that would expand the current supply of disability supports involves an associated reform of the income security system. There is significant work to be done to repair the disability income system in Canada, which is inadequate and ineffective. The Caledon Institute has argued, for example, that it is inappropriate for an estimated 500,000 Canadians with severe and prolonged disabilities to be on welfare. That program was designed as a last-resort safety net. It never was intended as a long-term income guarantee.

We have recommended that Canadians who qualify for welfare because of severe and prolonged disabilities be eligible for a newly-designed monthly income payment that would be paid for and delivered by the federal government [Mendelson, Battle, Torjman and Lightman 2010]. This so-called “Basic Income”

would resemble in its design the federally-delivered Guaranteed Income Supplement (GIS), which pays a monthly non-taxable benefit to seniors who have a low income and are living in Canada. Just like the GIS, payments would fall with increases in other income, allowing recipients the option of working to the extent that they are able. Labour market participation would not jeopardize eligibility for income support.

Under this proposal described in detail in the Caledon Institute report, benefits would be higher than current social assistance payments. Unlike welfare, the new program would be indexed to cost-of-living increases. Neither would applicants be required to divest themselves of most of their assets as under existing welfare requirements.

Finally, benefits under the proposed Basic Income program for persons with severe and prolonged disabilities would be portable on a pan-Canadian basis. Recipients would remain eligible if they moved to a different region of the country — say to be closer to friends or family, or to seek an easier climate.

But federal responsibility for a Basic Income that would remove a large proportion of social assistance recipients from welfare would result in a windfall gain to the provinces and territories. The Basic Income proposal would require all jurisdictions, under a negotiated agreement, to reinvest these savings in their supply of disability supports.

The National Child Benefit serves as a policy prototype for this arrangement in which the federal government assumed primary responsibility for the payment of income benefits on behalf of children under age 18. Provinces and territories, for their part, would no longer provide income benefits to children through their welfare system but would be required to reinvest their resulting social assistance savings in benefits and/or services for low-income families with children.

C. SOCIAL INSURANCE

Some form of social insurance might be considered as a financing option to enable the purchase of disability supports, whether provided in a residential facility or at home. Social insurances generally are employed in the event of a shared risk that affects a substantial proportion of the population. In this case, it would be the provision of supports for both persons with disabilities and an aging population.

Various proposals have been put forward for a social insurance plan to sustain and expand public health coverage in Canada [Grignon and Bernier 2012]. This policy option would represent a significant shift as Canada's social insurance experience has been confined to income security programs that protect against

clear work-related risks, such as unemployment, work injury and retirement. Benefits are paid — at least in theory — if contributors fall victim to the risk from which protection has been purchased.

Several developed nations have in place a social insurance model to help pay for long-term care that includes both the provision of disability supports and supervised residential placement. Germany, Japan, Korea, the Netherlands and Luxembourg provide universal coverage for long-term care through a plan that operates much like the Canada/Quebec Pension Plan.

In Germany, for example, participation in the Long-Term Care Insurance Plan is mandatory. Since 2008, total contributions for the first €44,550 (\$55,257 Canadian) of annual income are 1.95 percent, split equally between employer and employee [CARP 2011]. Pensioners must contribute the amounts themselves and Unemployment Insurance covers the contributions for the unemployed.

Long-Term Care Insurance in Germany offers a number of benefit options, which can be adjusted according to need [Arntz et al. 2007]. Every six months, recipients must choose cash, in-kind benefits or a combination of the two. Cash benefits are available for individuals who require lighter care or home care services. In-kind benefits are intended for those who need more intensive care in nursing homes.

While a strong program, several problems have been identified in its design. Because long-term care insurance is intended to make only a baseline of care available, many households purchase supplementary private long-term care coverage. As of 2009, more than 1.6 million Germans owned additional private insurance [CARP 2011]. Moreover, the program is not fully financed by premiums. These will need to rise in future as a result of the growing ratio of recipients to non-recipients of long-term care.

Despite these challenges, a designated fund for long-term care would represent a substantial advance over Canada's system, which consists of a patchwork of programs supported through tightly-stretched provincial/territorial budgets and user fees. Another plus for the German system is its formal recognition of caregivers and the provision of benefits through the long-term care fund. (The needs of caregivers and associated policy responses are explored in another paper in this series.)

There may be a danger, however, for nations to employ too many earmarked contributions as a financing instrument for publicly provided goods and services. Governments need a substantial and solid pool of general revenues in order to meet their wide-ranging responsibilities. They may not want to set a precedent of tying every social need to a specific financing arrangement.

D. INDIVIDUAL SAVINGS ACCOUNTS

Another policy option to improve the supply of disability supports involves individual savings accounts for the purchase of care at home. A tax break could be provided as is now the case for Registered Retirement Savings Plans. Unlike the social insurance option, contributions to these accounts would be voluntary. A new measure could be designed like a Registered Education Savings Plan or Tax Free Savings Account.

Governments could create designated registered savings plans with tax exemptions on condition that the money saved is actually used for long-term care services. As with Canada's Registered Retirement Savings Plan (RRSP), tax exemptions could be offered at the front end: the portion of income saved in the medical savings account (MSA) would not be taxed, but withdrawals from the account to pay for long-term care services would be taxed. Alternatively, as with the Tax Free Savings Account (TFSA), the portion of income saved in an MSA would be taxed, while the income generated by the fund would be exempted. MSAs have been in place in Singapore since 1984 (known as Medisave), although the scheme is used mostly to pay for acute health care services (Lim 1998) [Grignon and Bernier 2012: 6].

The Canadian Life and Health Insurance Association proposed a form of Registered Education Savings Plan (RESP) for long-term care:

In such a product, Canadians would be permitted to contribute a certain amount of money each year to save towards long-term care costs. Similar to RESPs, contributions by Canadians would be supported by grants from the Government of Canada. An RESP-type vehicle offers a number of advantages over alternative savings vehicles. All investment income generated in this type of savings vehicle is tax sheltered as long as it remains in the plan. Moreover, when the money is withdrawn and used for its intended purpose, the plan earnings and government contributions generally are taxed at a lower rate than they otherwise would be. Finally, because the government provides grants which help lever the individual's contributions, such a product is attractive for modest income earners for whom any tax deferral benefits are modest relative to those in higher income tax brackets [CLHIA 2012: 8].

Under tax-assisted options, Ottawa could make a contribution on behalf of low- and modest-income households, as it currently does for the Canada Learning Bond and Registered Disability Savings Plan. That component would help counter the argument that these types of arrangements disproportionately benefit households that are financially well-off.

RECOMMENDATIONS

The following measures represent a set of policy options for improving the quality of disability supports and for expanding their supply in order to meet the growing need for these essential goods and services. While provinces and territories play the primary delivery role in relation to disability supports, the federal government can collaborate with provinces and territories with respect to:

- ▮ improving the governance of disability-related programs
- ▮ enabling a shift to individualized funding.

The federal government can also provide vital leadership in this policy domain by:

- ▮ introducing a government-wide national strategy that integrates the work of several relevant departments and agencies, including Employment and Social Development, Health, Finance, Veterans' Affairs and the Public Health Agency of Canada.
- ▮ enhancing financial assistance delivered through the tax system
- ▮ investing in the supply of disability supports through a newly-created Disability Supports Fund
- ▮ creating a new federally-delivered and funded income security program that would replace social assistance for persons with severe disabilities, and would free up provincial and territorial funds for investment in the supply of disability supports
- ▮ exploring new financing possibilities including a national social insurance or individual savings accounts.

CONCLUSION

This paper puts forward several options for improving the quality of disability supports and for expanding their supply in order to meet the growing need for these essential goods and services. While there are a range of possible policy options, the best-case scenario would involve federal assumption of responsibility for income security in respect of persons with severe and prolonged disabilities, with an associated provincial/territorial investment of the resulting windfall into disability supports. In the absence of this major reform, the next-best scenario would be a federal-provincial cost-sharing arrangement around disability supports.

Improving both the quantity and quality of disability supports would make great strides on two significant policy fronts: the disability agenda and health care reform. An expanded supply of disability supports coupled with more effective delivery would enhance the quality of life not only for persons with disabilities — but for all Canadians as we age.

ENDNOTES

1. Disability supports refer to various goods and services that help offset the effects of a disabling condition. These generally fall into two main categories: technical aids and equipment, and personal services. Technical aids and equipment include such items as wheelchairs, visual aids, volume control devices and prosthetic appliances, and work-related equipment such as scanners, TTDs (teletypewriter devices) and large computer screens. This category also includes health-related goods such as special dressings, breathing machines and dialysis equipment. Personal services consist of several components. Attendant services provide assistance with personal needs such as feeding, bathing and dressing. Homemaker services help with household tasks such as shopping, meal preparation and home maintenance. Home health care involves health-related functions (e.g., administering medications, changing bandages, cleaning breathing tubes and carrying out services, such as dialysis, at home).

2. Principles such as self-determination, comprehensiveness, accessibility, portability and accountability have been identified over the years in numerous disability-related reports. Self-determination means that all services would be self-directed and self-managed in order to meet individual requirements. Comprehensiveness means that a wide range of disability supports would be available within a coherent system. Accessibility implies that disability supports would be available to all Canadians who need them. Portability seeks to ensure that persons with disabilities have access to the supports they require in any part of the country without having to establish residency, undergo a waiting period or 'present with' a certain medical condition. To honour the principle of accountability, consumers must be actively involved in the design, delivery and assessment of disability supports.

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Renewing Canada's Social Architecture is a collaborative project involving researchers from the Mowat Centre, the Caledon Institute for Social Policy, the Institute for Competitiveness and Prosperity and the Institute for Research on Public Policy. The purpose of the project is to advance public dialogue on our social architecture, and highlight areas where our core social programs and policies require modernization to meet Canadians' needs. Each report contributed to the project is the responsibility of the authors alone, and does not necessarily reflect the views of the other contributors or organizations.

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