

Three Policy Issues in Deciding the Cost of Nursing Home Care: Provincial Differences and How They Influence Elderly Couples' Experiences

Trois enjeux politiques en matière de décisions sur les coûts des services en maison de soins infirmiers : différences entre les provinces et influences sur l'expérience des couples âgés



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Abstract

Nursing home care is subsidized in all Canadian provinces, but residents must personally contribute to the cost. This paper explores policy issues that have led to differences in costs of nursing home care among provinces, and how policy and cost differences influence the experiences of married couples when one spouse requires nursing home care. The paper is based on a multiple-case study of three Canadian provinces, each of which had a different system for determining personal contributions to the cost of care. Cross-case analysis of payment systems showed that provinces addressed

three main policy issues in determining the cost of care: (a) what costs should be the responsibility of nursing home residents, (b) how subsidies should be determined and (c) how community-dwelling spouses of nursing home residents should be assured of an adequate income. In provinces with policies that resulted in higher care costs to couples and lower amounts of income and assets available to the community-dwelling spouses, study participants described reduced discretionary spending, increased financial concerns and perceptions of system unfairness. This paper discusses the implications of these three policy issues and recent related changes to provincial policies.

Résumé

Les maisons de soins infirmiers sont subventionnées dans toutes les provinces, mais les résidents doivent personnellement contribuer aux coûts. Cet article examine les enjeux politiques qui ont mené à des différences entre les provinces quant aux coûts pour les services en maison de soins infirmiers. Il examine également de quelle façon les politiques et les différences de coûts influent sur l'expérience des couples mariés où l'un des deux conjoints nécessite des services en maison de soins infirmiers. L'article se fonde sur une étude de cas multiples effectuée dans trois provinces canadiennes, lesquelles emploient différents systèmes pour déterminer le montant des contributions personnelles au coût des soins. L'analyse transversale des systèmes de paiement montre que les provinces ont fait face à trois principaux enjeux politiques au moment de déterminer le coût des soins : (a) quels coûts devraient être sous la responsabilité des résidents en maisons de soins infirmiers, (b) comment doit-on déterminer la nature des subventions (c) comment peut-on assurer un revenu adéquat pour les conjoints qui demeurent dans la communauté. Les participants à l'étude qui vivent dans les provinces où les politiques donnent lieu à des coûts de services plus élevés pour les couples et à un revenu et des biens moindres pour le conjoint qui demeure dans la communauté indiquent une réduction de leurs dépenses discrétionnaires, un accroissement des préoccupations financières et une perception d'injustice devant le système. Nous abordons les répercussions de ces trois enjeux politiques ainsi que les récents changements liés aux politiques provinciales.

Nursing home care is subsidized in all Canadian provinces, but residents must personally contribute to the cost. These personal contributions differ greatly from province to province (CHA 2004; Kirby 2002). The purpose of this paper is to explore policy issues that have led to differences in costs of nursing home care among provinces, and how policy and cost differences affect the experiences of married couples when one spouse requires nursing home care. The paper focuses

on the situation of married couples because they are particularly financially vulnerable: they must pay for nursing home care on top of the community-dwelling spouse's expenses, which remain largely unchanged. (*Nursing home care* refers to Type II care as defined by the Federal/Provincial Working Party on Patient Care Classification [1973]: facility-based care with availability of supervision, assistance with activities of daily living, personal care on a continuing 24-hour basis, medical and professional nursing supervision and provision for meeting psycho-social needs.)

Nursing home care was never an insured service under the *Canada Health Act* (1984) or previous Acts insuring hospital and physician care. Provinces therefore developed their own payment mechanisms for it and other long-term care services (Kirby 2002; CHA 2004). Although nursing home care existed when the forerunners of the *Canada Health Act* were passed, it was presumed that ensuring an adequate income for older adults would enable them to pay the cost of nursing home care (Alexander 2002; Kirby 2002). However, the cost of care has escalated to the point where it costs at least \$110 per day, or approximately \$50,000 per year (Alberta Health and Wellness 2002; CHA 2004). This amount is about equal to the average combined income of older adult married couples (Statistics Canada 2004), who comprise about 16% of nursing home residents (Rockwood et al. 1994). Therefore, provinces subsidize the cost of care for residents who cannot afford it.

Method

In order to understand how different mechanisms of paying for long-term care might affect community-dwelling spouses of nursing home residents, the author conducted a multiple case study involving three provinces in 2002/03 (Stadnyk 2005). Previous research by the author showed that in Canada, the provinces and territories used three main systems to determine the cost of nursing home care (Stadnyk 2001). Each provincial case was chosen to represent one of the systems. Alberta, the first case, used a flat-fee system. The per diem rate charged for care (approximately \$30 per day in 2002/03) was based on public pension incomes available to individuals. This system was also used in the territories. Manitoba, the second case, used an income-tested system. The per diem rate (approx \$30 to \$60 per day) was based on the couple's income. Similar systems were in place in British Columbia, Saskatchewan, Ontario and Quebec, though per diem rates varied widely. Nova Scotia, the third case, used an income- and asset-tested system at the time the study was conducted, although that province's system has since changed. The couple was responsible for paying the full cost of care (\$120 to \$200 per day) and could apply for a subsidy if they were unable to afford the rate. The couple's income and assets were considered in determining eligibility for subsidy. Similar systems were in place in the other three Atlantic provinces.

Each case study included qualitative interviews with 16 to 19 spouses of nursing

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home residents, interviews with four to six key informants and a review of policy documents. All spouses had partners aged 65 and over and lived within 100 kilometres of a major urban centre. The convenience sample of participants was recruited through several area nursing homes. The study was designed to explore a range of participant experience, rather than providing a representative sample of spouses in each province. The sample demonstrated diversity regarding participants' age, sex, health, income and assets (Table 1). While age and health status were comparable in the three provinces, income and assets differed. As might be expected, participants who were most affected by the payment policies of each province were somewhat more likely to participate in the study. Participants in Manitoba had higher incomes on average and so experienced higher personal costs in Manitoba's income-tested system. Participants in Nova Scotia had more assets, resulting in higher personal costs in Nova Scotia's income- and asset-tested system.

Qualitative, thematic analysis of the spousal interviews focused on changes in financial situation and related lifestyle changes. Document analysis and key-informant interviews (representing the viewpoints of policy, service, caregiver support groups and financial planners) were used to examine policies and practices related to payment for nursing home care. Interviews were conducted between July 2002 and May 2003. Document analysis continued until January 2007 because of changes to payment systems in Alberta and the Atlantic Provinces. Using methods described by Marshall (1999), cross-case analysis explored differences in spousal experiences and how these related to policy differences.

TABLE 1. Age, sex and self-reported health status of participants in each case

	Alberta case	Manitoba case	Nova Scotia case
Number of participants	16	17	19
Age			
Mean	77	74	77
Range	57–84	60–89	61–94
% Female	75%	59%	53%
Self-reported health			
Excellent/very good	12%	24%	26%
Good	50%	41%	42%
Fair/poor	37%	35%	31%
Income			
Participants' average family income ^a	\$41,394	\$52,789	\$42,029
Average income in province ^b	\$53,700	\$48,500	\$47,600
% of participants with income below provincial average	50%	41%	47%

TABLE 1. Continued

Assets			
< \$5,000	12%	19%	11%
\$5,000 to ≤ \$100,000	29%	19%	26%
> \$100,000	41%	25%	42%
Not reported	18%	37%	21%

^a Three Alberta, two Manitoba and four Nova Scotia participants declined to share income information; average incomes may be higher than these figures indicate.

^b 2003 average incomes for married couples. *Table 202-0403 – Average total income, by economic family type, 2006 constant dollars, annual*, CANSIM (database), by Statistics Canada <<http://www.statcan.ca/english/Pgdb/famil05a.htm>>. (Retrieved June 1, 2009.)

Results

Thematic analysis of spousal interviews showed that spouses' experiences differed by province. Provincial differences in how nursing home costs were assessed influenced couples' spending patterns, financial concerns and perceptions of fairness of the costs. An examination of the participants' main cost-related concerns, in conjunction with analysis of documents explaining cost-related policies, revealed three key questions that each province had to address in developing policies regarding the personal costs of nursing home care: (a) What costs should be the responsibility of nursing home residents? (b) What subsidizing mechanisms should be used for people who cannot afford to pay for nursing home care? (c) What mechanisms are in place for married couples to ensure that the community-dwelling spouse has an adequate income?

The way each province approached these questions, and the payment systems that resulted, created different experiences for participants. Following is a discussion of each question, incorporating study findings and significant policy changes that have occurred since the study was conducted.

What costs should be the responsibility of nursing home residents?

The cost of nursing home care includes accommodation (room and board) and health-care (nursing and personal care). Accommodation costs are estimated at approximately \$20 to \$50 per day (F/P/T Advisory Committee on Health Services Working Group 2000). Alberta and Manitoba policies made specific mention of their commitment to fund healthcare costs (Alberta Health and Wellness 2002; Manitoba Health 2002). The Nova Scotia policy (prior to 2005) was that persons who could afford to do so should pay the full cost of their nursing home care (NS Department of Health 1998).

The main difference in experience resulting from the two policy stances was that most Nova Scotia residents were paying far more for nursing home care, sometimes up to \$200 per day, in contrast to \$30 to \$60 per day in the other two provinces. The impact of having to pay the full cost of care resulted in more changes in discretionary

spending, as well as putting some expenses “on hold.” In addition, Nova Scotia participants were aware that they were paying care as well as accommodation costs, and that this was not the case outside Atlantic Canada. Nova Scotia citizens became politically active at the time the study was conducted. They argued that the public healthcare system should cover all medically necessary services, even though the *Canada Health Act* was limited to physician and hospital services. They felt discriminated against because the illness of their spouse demanded a location and type of treatment that was not insured. Their lobbying efforts and political events contributed to a complete change of the system in Nova Scotia. As of January 1, 2005, Nova Scotia policy clearly articulated the difference between care costs and accommodation costs, and committed to charging citizens for accommodation costs only (NS Health 2004a,b).

What subsidizing mechanisms should be used for people who cannot afford to pay for nursing home care?

Some citizens do not have sufficient income to pay for nursing home care, even in those provinces with lower rates. In Alberta at the time of this study, nursing home residents paid a flat fee that was calculated in such a way that those citizens receiving basic pensions would be able to afford the cost of care. Albertans with low incomes (typically, those who qualify for the federal Guaranteed Income Supplement [GIS]) had access to the Alberta Seniors Benefit (ASB) (Alberta Seniors 2003). With this additional supplement, they had sufficient income to pay for nursing home costs and retain a small allotment for personal expenses. Subsequent to spousal interviews conducted for this study, the ASB added a *supplementary accommodation benefit* targeted to low-income nursing home residents to offset increases in nursing home costs in 2003 (Government of Alberta 2003). Therefore, Alberta’s solution to the cost of nursing home care was to charge everyone the same rate, but offer income subsidies to enable poorer citizens to pay their cost of care.

Although Alberta community-dwelling spouses in the study found their incomes significantly reduced by paying for nursing home care, most did not describe changes in their discretionary spending. A few were concerned about their financial future. Those who were most vulnerable had low incomes or unusual expenses. Several people who had not applied for GIS and were entitled to it struggled or relied on family support, sometimes for several months, before they found out about their entitlements. Because the Alberta system had no formal financial assessment of nursing home applicants, it relied on low-income nursing home applicants to collect the ASB or to identify themselves as having financial problems so that they could be assisted to apply for federal or provincial income supplements. Recent increases in the cost of nursing home care may force low-income applicants to identify financial issues earlier in the placement process.

In Manitoba, a maximum per diem rate for nursing home care was set (\$62 in 2002/03), and a rate reduction on a sliding scale was offered to people whose income was below a certain level (approximately \$48,000 for a couple in 2002/03). The rate was calculated based on the couple's combined income in the previous year. The rate could be appealed (Manitoba Health 2002). In the study, Manitoba participants described reductions in discretionary spending, worries about the costs of care in the future and erosion of savings. Participants who experienced the greatest financial impact had incomes in the mid to high range of those eligible for rate reductions. The sliding scale used to calculate nursing home rates left all community-dwelling spouses with the same amount of income (unless their income was above the scale maximum). Therefore, those who were used to more income had to make more changes in discretionary spending.

In Manitoba, participants raised issues about the fairness of paying different rates for the same care. Participants sometimes equated paying a higher rate with being penalized for having lived carefully in the past, and therefore having more income and savings.

In the Nova Scotia system, at the time this study was conducted, income and assets were both applied to nursing home costs (NS Department of Health 2002a,b). This approach created a more complicated and personally intrusive assessment because assets had to be verified. (Residents and their spouses had the option of avoiding the assessment process if they agreed to pay the full cost of care.) The subsidization system in place in Nova Scotia was described by the Department of Health as a "social welfare model" (NS Health 2004a,b), requiring people to spend down their assets until they qualified for a subsidy (the *financial takeover date*). When residents were subsidized, they continued to pay a significant portion of their income towards the cost of care, with the Department of Health covering the rest of the costs. Those persons who were subsidized also had their medical transportation, pharmacare co-payment, eyeglasses, hearing aids and dental services funded (NS Department of Health 2002a,b), as is the case for persons who receive their income through provincial income assistance programs.

As a result, there were two main categories of nursing home residents: those who were paying the full cost of care and those whose costs were greatly subsidized by the government. Subsidized persons severely depleted their personal resources as a result of the spending-down requirement.

In the study, Nova Scotia participants showed more restraint in their discretionary spending and a tendency to delay major purchases, either until the financial takeover date was reached or until the nursing home resident had died. Participants had more concerns about their future financial situation than were expressed in other cases, particularly regarding erosion of savings and having enough money to meet the needs of both spouses. These concerns appeared to be more common among unsubsidized couples. The strongest difference in the Nova Scotia case was in the magnitude of

participants' concerns about the fairness of the system. The comparison of the privileges enjoyed by subsidized residents rankled the participants who were paying the full cost of care, as did comparisons with the systems in place in other parts of the country.

Nova Scotia participants were intolerant of the invasive process of having their assets assessed and used towards care costs. Both during and after the study, there were changes to the rules regarding which assets would be applied to the cost of care, made in response to complaints about the unfairness of having to deplete assets such as savings or the principal residence. Finally, the practice of applying assets to the cost of care was abandoned altogether in January 2005 (NS Health 2004a,b).

What mechanisms are in place for married couples to ensure that the community-dwelling spouse has an adequate income?

The third issue was to find a way to ensure that community-dwelling spouses could meet their own expenses. In Alberta, the assumption was that federal and provincial supplements would ensure sufficient income for the community-dwelling spouse. However, for poorer participants in the Alberta case, the cost of nursing home care posed hardship and required low-income spouses to use savings or enlist the help of family members to make ends meet. Spouses who were younger than 60 did not qualify for pensions, and this meant that there was simply not enough money for living expenses (unless the community-based spouse was working) because most of the couple's income was used for the cost of care.

In Manitoba, in contrast, the community-dwelling spouse's needs were explicitly addressed in the way that per diem rates were set. When the couple's income was assessed for assignment of the per diem rate, an *allowance for spouses* was automatically assigned to the community-dwelling spouse (Manitoba Health 2002). The allowance was \$1,880 in 2002/03 and was adjusted yearly. The second mechanism in place to protect community-dwelling spouses was an annual rate appeals process. The appeals process was set up specifically to address unusual expenses of community-dwelling spouses, such as mortgage payments or support of dependents.

As mentioned previously, participants whose incomes were in the higher range of those who were eligible for rate reductions experienced a reduction of disposable income compared to when they lived with their spouse. Many community-dwelling spouses viewed the appeals process as threatening and the requirement to record and justify a yearly budget as tedious. Problems were also experienced by working spouses. Because they usually had a higher income than their spouse in the nursing home, part of their income was used to pay the bill for nursing home care. These spouses also had work-related expenses and personal financial goals, such as saving for their retirement, that conflicted with the requirement to pay for nursing home care.

Because the Nova Scotia system required that assets be used to pay for care, it

needed a process to divide the assets of married persons. The province's solution was to invoke the principles of the *Nova Scotia Matrimonial Property Act* (1989), which specify how assets are to be divided should couples dissolve their marriage (NS Department of Health 1998). This measure resulted in most property being split 50–50 with the spouse. For couples who were financially well off, this requirement created great concern about fairness but few immediate hardships. However, for couples who had low or middle incomes and modest assets, losing half their savings was devastating. For these couples, savings were regularly used to supplement income in case of unusual expenses. Now, after years of careful saving or investment, they were suddenly required to spend large amounts of these savings.

As the Nova Scotia system evolved, a more lenient, needs-based approach was taken to assessing the amount of income to be left with the community-dwelling spouse, particularly for lower-income couples. Further changes to the system resulted in the spouse being able to keep more assets (NS Department of Health 2002a,b). Community-dwelling spouses who had been assessed differently in different stages of policy evolution had spouses who lived side by side in nursing homes. The participants' perceptions that nursing home residents had been assessed differently (and unequally) contributed to the worries and fairness issues that were raised.

The January 2005 changes resulted in a system similar to Manitoba's, with the amount that couples paid based on their joint income, and the community-dwelling spouse being left with a minimum allowance (\$1,210 in 2005). However, there was no appeal process available to raise the minimum allowance for spouses who found themselves in unusual financial straits. Also, income earned by community-dwelling spouses was no longer exempt from financial assessment as it was in the past (NS Health 2004a,b). Therefore, while the interests of middle- or higher-income spouses were protected by the changes, there was the potential for lower-income or working spouses to be more vulnerable.

Discussion

In a recent document reviewing the Canadian long-term care system, the Canadian Healthcare Association recommended that "consistent publicly funded coverage should be provided for facility-based long term care services, while charging the resident a reasonable accommodation fee" (CHA 2004: 66). Public funding of the healthcare component of nursing home care would demonstrate "the principles of shared risk inherent in Canada's value system" (CHA 2004: 66). It would recognize that nursing home care is not an accommodation choice so much as a source of needed health supports for many older adults with chronic illness and disability. A "reasonable" accommodation fee would reflect the market price of similar lodging and food services (CHA 2004). There is evidence that some agreement has been reached on this point

in Canada, given the changes in Nova Scotia, New Brunswick (NB Department of Family and Community Services 2007) and most recently, similar changes in Prince Edward Island (PEI Department of Health 2009). However, while Newfoundland and Labrador has taken similar measures to reduce the cost of nursing home care to a maximum of \$2,800 per month, the province describes personal contributions as payment towards the full cost of nursing home care (Government of Newfoundland and Labrador 2000). While this seems like a small point, ideologically it is significant because it indicates that citizens are expected to contribute to healthcare costs as well as accommodation costs. At one point, Alberta appeared to be exploring the idea of using private long-term care insurance to cover the full cost of nursing home care (Alberta Health and Wellness 2005). In such a system, what would be the fate of people who are ineligible or unable to afford long-term care insurance? Would they be liable for both care and accommodation costs?

There is also agreement across Canada that the personal cost of nursing home care should be based on available income rather than assets, although Newfoundland and Labrador continues to apply cash assets to the cost of nursing home care (Government of Newfoundland and Labrador 2000). After Nova Scotia changed its system in 2005, New Brunswick and Prince Edward Island followed in 2006. This policy question remains important in other jurisdictions, most notably the United States, where the personal requirements for nursing home care payments in many states resemble the old systems in the Atlantic Provinces and cause hardship for families (Williams et al. 2006).

A third issue is whether residents should pay a flat fee or a fee based on income. While in theory it seems reasonable that people who earn more should pay more, in practice this assumption was not well tolerated by study participants. In his study of attitudes of Canadians towards redistributive justice, Graves (2001) noted that at the macro level, Canadians support redistributive economic measures, but at the individual level, citizens who are economically secure are much less supportive of redistributive measures than those who are not secure. However, the flat-fee system has its own problems because it is likely to disadvantage lower-income couples. An unresolved issue is the wide discrepancies that remain in the personal costs of nursing home care in different Canadian jurisdictions (for a comparison, see NUPGE 2007). Presumably, these differences create inequity for Canadians, even when differences in the cost of living in different jurisdictions are taken into account. Should differences in accommodation costs be tolerated in a needs-based health service?

Conclusions

From the perspective of low-income community-dwelling spouses, or those with unusual demands on their financial resources, it appears that the most desirable policies

addressing the personal costs of nursing home care would combine a stated allowance for the community-dwelling spouse with some mechanism that takes into account the potential for unusual expenses, whether or not a flat fee or income-based fee is used. The mechanism could take the form of a more detailed financial assessment or an appeals process. Either of these must be conducted in a way that is supportive, rather than threatening, to the community-dwelling spouse. There is the potential for caregiver support groups or seniors' groups to assume an educative, supportive or advocacy role in the assessment or appeal process.

While recent changes have increased similarities among provincial payment mechanisms for long-term care, the Canadawide, consistently funded system recommended by the Canadian Healthcare Association (2004) does not yet exist. Provincial differences in the cost of nursing home care to individuals continue to create healthcare inequities for Canadians. In addition, spouses of nursing home residents continue to face additional inequities because of provincial differences in spousal allowances and mechanisms that ensure spouses' financial well-being.

ACKNOWLEDGEMENTS

This project was funded by a grant from the Drummond Foundation. This paper evolved from research for the author's doctoral dissertation at the Department of Public Health Sciences, University of Toronto. She gratefully acknowledges the support of Dr. Victor Marshall, her adviser, who encouraged her in the development of these ideas.

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