

Comfort, Security, Dignity:
The Veterans Independence Program, A
Policy History

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CONTENTS

Preface.....i-ii

List of Acronyms.... iii

Introduction.....1-4

Chapter 1: Origins of the Aging Veterans Program5-42

Chapter 2: The AVP ‘Pilot Project’ 1981-198343-56

Chapter 3: Extension of AVP57-76

Chapter 4: From the AVP to the VIP: The George Hees Era77-111

Chapter 5: The VIP, 1989-1993: Caseload Expansion and Fiscal Restraint112-159

Chapter 6: From Entitlement to Need: Transforming the VIP.....160-217

Conclusion.....218-226

Appendices...227-232

References....233-235

PREFACE

This policy history of the Veterans Independence Program, Canada's national home care strategy for veterans, is based primarily on an exploration of 85 linear feet of archival records pertaining to the program's origins and subsequent development over the past quarter century, a collection currently housed at Veterans Affairs headquarters in Charlottetown PEI. The archival research was supplemented by interviews with 25 individuals who played important roles in the program's history as policy-makers, administrators, district counselors, external advisors, or representatives of veterans organizations. During the summer of 2003 Veterans Affairs provided me with wide access to the rich body of correspondence, policy memoranda, reports, background studies, and minutes of meetings which constitute the historical record of the VIP. Department officials and others involved with the program were also generous with their time in granting me interviews to discuss their recollections of formative moments in its evolution. I am particularly grateful to Darragh Mogan, previously Director-General of Health Services for Veterans Affairs, and David Pedlar, Director of Research for the department, for their commitment to the writing of a history of the VIP, to the assistance of Stephanie Larter in the department's Records Centre, to Michael Zinck and Mary Scott of its Research Directorate, to Johanne Nault, formerly of Veterans Affairs Canada, and to Peter Neary for his advice and encouragement.

The importance of devising effective home care strategies for a rapidly aging Canadian population has never been more apparent or more widely discussed. Almost

twenty-five years ago Veterans Affairs Canada began the task of ensuring that aging veterans could live in comfort, security, and dignity in their own homes for as long as possible as an alternative to institutionalization. Exploring the significance of that journey is the purpose of this study.

LIST OF ACRONYMS

AA	Attendance Allowance
ADM	Assistant Deputy Minister
ARC	Adult Residential Care
AVP	Aging Veterans Program
CPC	Canadian Pension Commission
CCSI	Client-Centred Service Initiative
CSO	Canada Service Only (veteran)
CWA	Civilian War Allowance
DVA	Department of Veterans Affairs
DPPE	Directorate of Policy, Planning and Evaluation
FAC	Field Advisory Committee
GAC	Gerontological Advisory Committee
GIS	Guaranteed Income Supplement
MSVU	Mount Saint Vincent University
NCVA	National Council of Veterans Associations
NDP	New Democratic Party
OAS	Old Age Security
OSV	Overseas Service Veteran
RCVN	Review of Veterans Care Needs project
TAP	Treatment Accounts Processing
VAC	Veterans Affairs Canada
VON	Victorian Order of Nurses
WVA	War Veterans Allowance

INTRODUCTION

‘By the end of the first decade of the twenty-first century, Canada as a whole will face the same pressure for a diversity of age-related support services now faced by Veterans Affairs. Departmental experience in this area could form the basis for preparing age-related health and social services for all Canadians.’

-- Veterans Services Headquarters Management Review,
Aging Veterans Program - Extension, 15 June 1984

In recent years the cost of caring for an aging society has risen to the top of the Canadian political agenda at both the federal and provincial level. Ballooning health budgets, overcrowded emergency rooms, lengthy waiting lists for institutional care and the patchwork nature of home care are regular staples of media coverage of Canada’s health care landscape. These same issues also loom large in the recent Romanow Report, Building on Values: the Future of Health Care in Canada, commissioned by the federal government. Although the causes of a perceived ‘crisis’ in health care are complex, the relationship between population aging and rising health care expenditure is an ongoing and often ‘alarmist’ feature of current policy and media debate. Increasingly, it has also driven discussions around the need for a national home care strategy as a more cost effective alternative to the potentially crippling burden of institutional care, over the next three decades, for Canada’s burgeoning population of seniors.

A quarter of a century ago the Department of Veterans Affairs confronted similar concerns as it faced the demographic consequences of its aging population of First and

Second World War veterans and veterans of the Korean War. By the end of the First World War the Government of Canada had created a network of fifty hospitals and sanatoria to provide 10,754 beds for veterans across the country. By the 1960s the number of veterans hospitals had shrunk to eleven with a total capacity of 6871 beds. Faced with an aging population of increasingly indigent and elderly First World War patients, and growing difficulties in attracting doctors and nurses to work in what were becoming 'rest homes with obsolescent facilities' the Department of Veterans Affairs decided to get out of the hospital business altogether. Over the course of the 1970s 10 of its 11 veterans hospitals were turned over to the provinces in return for agreements guaranteeing space in provincial facilities for Canadian veterans requiring institutional bed care.

Although with the exception of St. Anne's in Montreal the department was no longer running hospitals or, more accurately, long-term care facilities itself, it still faced a substantial and ill-defined financial commitment to the much larger cohort of a million Second World War veterans, with an older age profile compared to the general population, who were now entering their retirement years. Through a gradual series of regulatory changes in veterans treatment benefits stretching from 1928 to 1966, veterans serving overseas in time of war gained the right to institutional bed care, financed by Veterans Affairs, in a long-term care facility. Out of the imperatives of this moral and fiscal commitment emerged a remarkable social policy experiment: Canada's first and to date only national home care initiative, the Veterans Independence Program. Launched in April 1981 as the Aging Veterans Program - the 'VIP', as it was renamed in 1986, has become one of Canada's least known but most successful examples of community-based

home care as an alternative to institutionalizing the elderly.

The purpose of this historical policy review of the VIP is twofold. First, the story of the program's origins, evolution, and pioneering work on behalf of elderly veterans is an important chapter in the still underdeveloped history of Canada's response to an aging society in last quarter of the twentieth century. As will be shown in the pages to follow, through the Veterans Independence Program, the Department of Veterans Affairs anticipated the needs of an aging population and developed coherent, effective, and cooperative policy models for the delivery of community-based home care, albeit for a select clientele, from one end of the country to another long before debates around the need for a national home care strategy emerged in force during the 1990s. The VIP, as an earlier in-house evaluation argued, was 'one of the few programs in Canada to fully experience the demographic aging of its clientele before [similar] impacts [were] felt at the national level.' It was also one of the first to embrace gerontological perspectives on the alternatives to institutionalization as well as the needs of caregivers. Its history thus provides a remarkable success story which deserves a wider audience as Canada as a whole now confronts similar challenges posed by a rapidly aging population over the next three decades. Second, as the VIP approaches its first quarter century and the numbers of its principal clientele of Second World War veterans have begun to shrink, it is timely to look back on the key decisions, turning points, and significant debates within the program's history to discover what can be learned from a policy cycle which saw its caseload grow from 300 to more than 87,000 veterans over its first decade before entering into a period of gradual decline in the 1990s.

Finally, the story of the VIP is also part of a major cultural and policy transition

within the Department of Veterans Affairs itself which has moved increasingly away from a heavily benefit-driven or pension focus to a more client-centred and needs-based approach to serving veterans and their families. As historian Julian Zelizer argues, 'by showing specific links between the past and present, [policy history] can provide policymakers with strategies for success. Explanations of how conditions stifled or supported previous initiatives can be instructive to those who design new programs.' It is to be hoped that, along similar lines, this policy history of the VIP's first quarter century will prove instructive to decision-makers within Veterans Affairs as the department once again charts a course for dealing with the needs of a changing clientele in the 21st century.

Chapter 1

ORIGINS OF THE AGING VETERANS PROGRAM

In the late autumn of 1957 Dr. E.B. Convery, Adviser in Geriatrics for the Department of Veterans Affairs penned a 'Charter for our Aged Veterans' which he forwarded to senior officials within the department. 'The time has come to develop a concentrated, coordinated programme to deal with the many facets of the problem of the ageing veteran (citizen),' Convery argued. By doing so the department could utilize its 'preferred position' to take the lead in Canadian gerontological research and policy development. It had hospitals, doctors, nurses, psychiatrists, and social workers, 'the very core of professional staff that could, in team work, point to a better understanding...and a thoroughly practical approach to the Ageing veteran (citizen) problem.' Moreover, its clientele faced a host of 'gerontological problems' including age discrimination, an extremely scarce supply of suitable homes 'which elderly people can afford'; mounting incidence of chronic and degenerative diseases that were 'block[ing] beds in the hospitals' and creating an 'alarming increase in the institutionalized aged', and a growing need for rehabilitation services due to the 'physical and emotional disabilities affecting an increasing number of older people.' Convery called upon the department to launch a program for aging veterans that would include day care in its hospitals, meals on wheels, rural home care, social and welfare visiting, regular health examinations, and close cooperation with the Legion and other veterans and senior citizens organizations in order to develop recreational and educational programs for Canada's aging vets. Such a 'Charter' that built upon the 'experience we have gained,' he argued, 'would be an added inspiration to the

whole field of Gerontology throughout the country.’

Convery’s vision was premature by almost a quarter of a century. But it remarkably foreshadowed many of the core ideas and initiatives which would ultimately inform the Aging Veterans Program launched in April 1981. The more immediate influences on the origins of the AVP, however, are to be found not in Convery’s memo but in the pioneering work of Dr. Jack MacDonell, one of the ‘founders of geriatric medicine in Canada’. In 1967 MacDonell started a geriatric ‘day hospital’ for aging veterans and their caregivers, the first of its kind in Canada, at Deer Lodge, the veterans hospital in Winnipeg where he was head of geriatrics, and his wife Asa, also a physician, was the assistant administrator. Prior to joining the medical staff at Deer Lodge MacDonell had traveled throughout Europe in 1960, with the aid of a fellowship from a Winnipeg women’s group which, as he recalled, ‘allowed me to visit geriatric units in the United Kingdom, Holland, Belgium, and Denmark where the organized care of the elderly was ten years or so ahead of North America.’ During his time in the U.K. MacDonell met Ferguson Anderson, Marjorie Warrens and Lionel Cozins, giants of British geriatrics in the post Second World War era. Anderson and Warren made a particularly strong impact on the young visiting physician from Canada. Their experience working as physicians in British Poor Law hospitals, amidst the degradation and misery of the indigent bed-ridden elderly, convinced them to develop a system of ‘home assessments’ so that the health and social conditions of the aged, which often resulted in their unnecessary institutionalization, could be seen in a broad social context. Anderson’s starting principle for geriatric medicine was that ‘older people are happier and healthier in their own homes if they are fit enough to be there and so desire.’ He also stressed the importance of a team-based

approach to care for the elderly which involved ‘the close collaboration of medical doctors and other professionals such as social workers and chiropodists.’ Bad feet, severe constipation or impacted ear wax - conditions all easily treatable at home - could frequently lead to misdiagnosis and unnecessary institutionalization of the aged. Home assessments could reveal the roots of such conditions as well as determine the capacity of family members to provide care.

The importance of both home-based assessments and multi-disciplinary team-based care were critical insights MacDonell brought back with him to Winnipeg. Before joining Deer Lodge as head of geriatric medicine in 1967, he experimented with these ideas at Municipal Hospital, initially a Winnipeg TB and polio treatment facility which, by the early 1960s, had transformed itself into mainly a chronic care hospital for the elderly once medical breakthroughs such as Salk vaccine and antibiotics had progressively eliminated the numbers of patients suffering from polio and TB. The treatment and discharge of patients with these diseases had always involved close consultations with family members concerning conditions for care in the home. At Municipal Hospital MacDonell began to develop a similar strategy for discharging the elderly.

Then came the matter of sending them back home. Who was there? How capable were they to look after the elderly client? We had to interview family and look at the entire home environment. Were there stairs up to the front door? How easy was it to get to the bathroom? Do they have to climb stairs to get to bed? Could they dress themselves? Were they continent? Could there be continence training? When we went through that program and thought they were ready to go home,

we'd be in contact with family all along, and then we'd say 'we would like to have a trial discharge, for maybe two weeks or a month, and see how things go.' And then we'd call on the VON to drop in at regular intervals... That was the basis of the program. And in a surprising number of cases it was possible to reduce the demand on long-term beds by at least 60 per cent.

Once he started work at Deer Lodge, MacDonell with the help of his wife Asa, launched a similar but far more ambitious program targeted at the hospital's aging veteran population. His first task was to create an assessment unit to discover who among the long-term care patients could be sent back to their homes. An empty ward was equipped with beds with sawed-down legs which could allow elderly patients easier access to getting in and out of bed and to bathrooms by themselves as part of a new program of continence training. He also began to feed patients, wherever possible, at shared tables rather in their beds, something which 'caused quite a ruckus.' MacDonell established multidisciplinary patient assessment teams, the first of their kind in Canada, composed of an occupational therapist, a physiotherapist, a pharmacist, a nurse, a doctor, and a social worker or Veterans Affairs welfare officer as well as one or two non-professional hospital staff members, who often knew the veterans best. 'So it was a program...We'd have team meetings on every patient....At these team meetings each one of these team members had examined the patient or gone to their home....And then from this assessment ward they were streamed either to long-term care or to home, with or without support.' In another innovation, some were streamed to visit the new geriatric Day Hospital MacDonell had established at Deer Lodge.

They didn't come in every day. They came sometimes twice a week or three times a week. They got a hot meal... They were assessed medically to see how they were getting along. They socialized. And this is what we found too, that many of them were quite lonely, and so a recreational system was set up at the day hospital.

Once the Day Hospital was up and running MacDonell then launched his fourth initiative, borrowed from his experiences with Ferguson Anderson and Lionel Cozins in England: a readmission program to provide respite care for the veterans' wives. 'I don't think the readmission program would have been started had we realized that the women needed so much support,' Asa MacDonell recalled. 'What the team found was that the wife...could stand it maybe for two months. And then she needed rest, so we'd bring them in, to give the wife a rest and also for us to have the chance to reassess the patient.' The biggest obstacle was convincing women, whose husbands had often lived in Deer Lodge for years, to take them back home.

They were skeptical To get the first few patients back home we promised that if something happened we'd take them back. After the program started...our phone rang literally day and night for two solid weeks. About 2:00 o'clock some poor wife, you know, saying 'I can't do this, I can't control it. You got to take him back.' And invariably we'd pick him up in an ambulance and 'whish' he was in the hospital. Well then word got around that 'hey they really believe in what they're doing. They really will help us.' So the program was a success....But if we hadn't

said, 'yes, that's fine, we'll pick him up,' and create some trust in the system, it wouldn't have gone far.

When wives reported difficulty in lifting their husbands in and out of the bath, Deer Lodge either paid for VON nurses to go into the home or brought the men into the Day Hospital twice a week to have baths. MacDonell's staff also assessed the physical layout of the veteran's home, before he was sent back. 'Is it on one floor or two floors. How are the kitchen facilities? How far is the bathroom? If they were not convenient we would see what we could do to make that patient more mobile and able to cope. If that wasn't within the realm of possibility, we would ask, 'how can we alter the physical setup in the home in order to make it compatible with day by day care?' A wheelchair pool was established which could be accessed by families so that the veterans could be moved about more easily. The MacDonells also created a system of social transportation to get the veterans to and from the Day Hospital.

We had two ambulances and at least five cars...and we used to use taxis if things got too busy. So we always brought the patients to the hospital, which was the way of home care. Medicine was provided. Prostheses were provided. Canes and crutches were provided. So before home care started, we had a program. It wasn't called home care. But that's the kind of support that, through the Day Hospital, we were able to provide. And maybe that's where the Veteran's Independence Program got the idea.

It is a point confirmed by a number of individuals central to the early development of the VIP. 'Jack MacDonell's work was the beginning of a huge era of change, not just within DVA, but with respect to the health system, especially in Manitoba,' Jeannette Edwards, director of Winnipeg's Regional Health Authority argues. 'He was far ahead of his time.' MacDonell's prescient innovations in geriatric day and respite care were all the more remarkable because they were financed through a combination of administrative savings imaginatively captured from within the Deer Lodge staffing budget by his wife Asa, through research support provided by Winnipeg's Age and Opportunity Centre, and through volunteer donations by the Winnipeg branches of the Canadian Legion, which purchased a van to help transport veterans and their caregivers to and from the Day Hospital. No additional direct funding for the Day Hospital initiative came from the Department of Veterans Affairs itself.

Winnipeg, a city of vibrant ethnic neighbourhoods and strong traditions of political and community activism, was fertile ground for such policy innovation in home care. In 1957 the city's Social Planning Council launched the Age and Opportunity Centre, one of first attempts in Canada to coordinate area planning and research on seniors' needs. It would become a springboard for developing programs in support of 'aging in place' within the city. The polio epidemic of the 1950s, which hit southern Manitoba particularly hard, also created an early interest in developing home care programs among hospitals treating its victims including Municipal Hospital where Jack MacDonell had worked. 'We didn't want to see these young people forced to live the rest of their lives in institutions,' Signe Hansen, one of MacDonell's colleagues at Deer Lodge, later recalled. In 1968, the Age and Opportunity Centre would recruit Evelyn Shapiro, a leading researcher on

community-based home care as its director. Through her work at the Centre as well as at the University of Manitoba, Shapiro helped to support Jack MacDonell's innovations through the geriatric Day Hospital at Deer Lodge. Five years later she would be invited by Manitoba's NDP government to help design and implement Canada's first provincial long-term care program in which home care became the single point of entry. 'We were the first province to treat nursing home beds as a scarce resource', Shapiro recalls. 'In other words, you went through the home care program. If you couldn't manage on home care...then you became a candidate for the nursing home...But nobody was going to go in unless they really couldn't be managed. That was a big, big push to start a home care program. And it started as a single entry system.'

Winnipeg was also the centre for the Aging in Manitoba project, one of North America's most ambitious longitudinal research studies on the health and well being of the elderly. Begun in 1971 by Betty Havens, a professor in community health sciences at the University of Manitoba, the study (which continues today) involved almost 9000 Manitobans over the age of 60. Havens, who like Shapiro would become a key advisor to Veterans Affairs in developing the Aging Veterans Program, explained Winnipeg's pioneering role in community-based home care in this way. 'The right people [were] in the right place at the right time...Sometimes you get a critical mass of people who have similar philosophies or ideologies or concerns and because they are in the same place at the same time [they] can move things forward with great strides...[more] than would be possible for any of those people in any other situation.' The mutually reinforcing leadership of Jack and Asa MacDonell, Evelyn Shapiro, Betty Havens, Signe Hansen, Yetta Gold, along with many others in Winnipeg's health and social services sector,

helped to make that city a focal point for developing innovative community-based alternatives to institutional care, ideas which would also feed into Canada's first provincial home care system launched by Manitoba's NDP government in 1974. 'And because they worked here,' Havens pointed out, 'in a sense you were selling VAC and others a product you could show them, not just that you talked about.'

By the mid to late 1970s Veterans Affairs was increasingly anxious to find such a product. Pressure came from two directions. On the one hand veterans organizations, such as the Canadian Legion, were lobbying intensively for the federal government to develop a national program to deal with the needs of aging veterans. And the solutions they favoured looked expensive. Pointing to long waiting lists, in the hundreds, for veterans seeking admission to chronic and domiciliary care in Department of Veterans Affairs institutions across Canada, the Legion appointed a committee, in 1976, to 'study programs for aging veterans and to recommend future policies.' High on their list for government action was the construction of 'special institutions for domiciliary or extended care for the aging veteran who is not enjoying normal health' as well as programs that would 'enable them to continue to reside in their own homes.' Pointing to Sunnybrook Hospital in Toronto, the Legion noted in 1975 that despite a recent \$11 million major expansion and renovation of that facility, 'its 400 beds are filled, there's an overflow of nearly 200 in a nearby building and a long waiting list. Most of the patients are First World War veterans. Others are from the Boer War. As yet, few WW II vets have checked in.'

This was the prospect which truly alarmed Veterans Affairs officials as they contemplated a potential doubling of applications for contract beds once the Second World War cohort, twice the size of its First World War counterpart, began reaching age

65 in the 1980s. Similar concerns about the costly over-institutionalization of Canada's elderly were emerging in discussions at the national level on health care reform. A 1976 federal-provincial Working Group on the Study of Health Services for the Elderly, for example, argued that '60% of the elderly presently residing in nursing homes could be maintained in the community with a minimum of support services.' In response to the Legion's keen interest in the problems of its aging clientele, emerging national discussions around home care, and Veterans Affairs own recognition that the 'dynamics of aging in the veteran population were...different from those related to the total population,' the department commissioned a study, early in 1977, on 'treatment policy options' for the next decade. Its report recommended that the department should 'provide the necessary medical treatment, care, and ancillary benefits and...arrange and/or finance delivery of those services...in the veteran's community environment, *either at home* or within an institution' in order to 'enhance the health and social well-being for eligible aging veterans and their spouses.' The study also recommended that, in accordance with 'current geriatric care philosophy', the department's 'client base...be broadened by the addition of eligible...spouses.'

In December 1977 the Minister of Veterans Affairs endorsed the strategy of providing 'a minimum standard of geriatric care and health services for all eligible veterans...arranged and/or financed by Treatment Services in the veteran's community environment at home or within an institution.' Home care dimensions of this policy would include 'home medical, other professional and non-professional support services, [and] home maintenance, modification and repair.' However, all such services should first be linked, where available, to existing universal provincial home care programs 'without

financial obligation' for Veterans Affairs. Where such services were non-existent, the department would purchase them for eligible veterans. Any new veterans' community and home based care strategy should incur no additional financial liabilities for the department, should integrate veterans into provincial long-term care systems, should not provide better services for veterans than were provided through provincial programs, and should assume that the purchase of home care services by Veterans Affairs would end whenever they became universally available through provincial health care plans. Such a strategy would also be contingent upon the provinces agreeing to the department's entry into 'the home support and community bed fields.'

A small working group led by the department's program medical advisor, Dr. Blair Mitchell, was struck early in 1978 to begin consultations with the provinces over how such a home care strategy might be integrated with their emerging home care programs. Prior to beginning these discussions Mitchell's group was strongly advised by the Privy Council Office to drop all references to including spouses in any Veterans Affairs home care scheme on the grounds they were a provincial responsibility. Ironically, even though the department was counting on the rapid development of provincial home care services to minimize its own level of involvement, the Privy Council Office also warned that some provinces might not look favourably on a veterans home care strategy lest it 'result in creating pressures from other Provincial residents for the establishment of a universal program.'

By mid-summer 1978, however, revised estimates predicting that the demand for Type I and Type II institutional care beds for veterans would jump by only 20 per cent between 1978 and 1985 rather than the 62 per cent originally forecast caused officials to

put on the brakes and recommend that the department ‘suspend development of home support services for the balance of 1978 in order to monitor provincial services.’

Ottawa’s switch to block funding of provincial health care, through Established Program Financing in 1977, had also freed up money allowing provinces to fund the development of ‘short and long-term home and related support services’. Given these circumstances, the development of a separate Veterans Affairs home support service was deemed unnecessary. A more appropriate strategy was simply to wait and see what the provinces did, and to ‘identify... opportunities for initiatives when provincial programs are stabilized. Unquestionably, the Canadian Legion will continue [to] intensify their representations for departmental action in this sphere.’

Other Veterans Affairs officials were less convinced there would not be a rapid growth in need for institutional beds, if home care alternatives were not quickly put into place. Veterans facilities charged only \$120 a month for domiciliary care, a rate which had not changed since 1949. ‘They were just like a magnet to draw in people who either had some degree of physical impairment...[or].. who didn’t have affordable housing,’ Darragh Mogan, one of the principal architects of the Aging Veterans Program later recalled.. ‘We would have had to build a lot of facilities. And so we looked at alternatives. This was the birthplace of the Aging Veterans Program. It was a community-based home care oriented alternative to the warehouse. That’s exactly what it was.’ The most critical pressure came from internal forecasts, undertaken in 1978, which also predicted a ‘geriatric crossover’ occurring in 1985 at which point the number of veterans over age 65 (330,000) would exceed the number under 65 for the first time in the department’s history. The aging of this group was ‘increasing faster than in the general population which is a provincial

responsibility.’ By late 1978 it had also become clear to most department officials that the ‘provinces won’t act as rapidly as we need too.’

As a result, a task force, composed of Dr. Blair Mitchell, Stu Tubbs, Darragh Mogan, Duncan Conrad, and Signe Hansen, was formed to devise a new and less expensive strategy for coping with the anticipated surge in demand for institutional care. Tubbs, a special advisor to the assistant deputy minister for Veterans Services, was a Second World War vet and amputee who had a longstanding interest in the needs of veterans’ caregivers. Mitchell was the department’s program medical advisor. Conrad had a background in social services and had worked as an area counselor for Veterans Affairs in Halifax. Hansen, previously the coordinator for Jack MacDonell’s Day Hospital at Deer Lodge, was now a program advisor in gerontology at departmental headquarters in Ottawa. Mogan, described by colleagues as the ‘godfather of the VIP’ had also been an area counselor for the department in southwestern Ontario during the 1970s before transferring to Veterans Affairs headquarters in Ottawa. He was not impressed by the bleak institutional lives of aging First World War veterans he had encountered during his days as a counselor. ‘There was no choice for them. You were either at home or you were put in the warehouse....That was the choice. And the warehouse was not a place you would put any friend, in my view,’ he later recalled.

The most important ideas shaping their work came from Manitoba, in particular the Deer Lodge Day Hospital where Hansen had worked prior to her move to Veterans Affairs headquarters. The task force traveled to Winnipeg to meet MacDonell and to get a first hand look at his Day Hospital. Through MacDonell they also encountered in action some of the key home care principles of Sir Ferguson Anderson. Anderson had been ‘a

good friend of the DVA for a long time' and provided 'generous assistance' as an advisor to the department in the early development of its Aging Veterans Program. In 1979 task force members also attended a four day conference on 'Alternatives to Long-term Care' hosted by the University of Manitoba, and met with Evelyn Shapiro and Betty Havens who were instrumental in designing Manitoba's Long-term Health Care Program, with its central focus on home care.

Additional influences on their work came from British Columbia, which had recently launched its own home care system; Quebec's new Centres Local de Sante Communautaire; Dr. Rory Fisher's geriatric day clinic at Sunnybrook Hospital; and initiatives being pioneered by Doug Rapelje, director of Homes for the Aged in the Regional Municipality of Niagara Falls. Rapelje was also experimenting with coordinating housekeeping and groundskeeping services to the elderly in their homes in order to provide alternatives to institutional care. The stress upon the importance of housekeeping and groundskeeping, which embodied core ideas of Ferguson Anderson, would become a cornerstone of the AVP. In the background loomed the presence of the Canadian Legion which was now embarked on its own active seniors housing and geriatric care initiatives for its 500,000 members. The Legion had recently formed an 'action committee on the care of the aging' which was lobbying Veterans Affairs aggressively for a new national program for aging veterans. 'Next summer, at their Dominion Convention, they will attempt to light a fire under us if that seems necessary,' deputy minister Bruce Brittain warned.

In December 1979, after almost two years of the study, the task force released an initial report. Its core message was summarized succinctly by Brittain in a memorandum

sent to his minister. The Department of Veterans Affairs policy towards aging veterans simply 'ignores reality', he argued.

[At] present... the department is getting into an indefensible position because [our treatment] policy is badly outmoded, highly discriminatory, and inequitable. It is expensive and not cost-effective; to a large degree it almost totally ignores the severe plight of many aged veterans and their spouses. A very significant number of veterans are in (expensive) hospital beds, not because they need to be but because we're unable to do the things that need to be done to keep them in the community...It is clear to nearly everyone that the unnecessary institutionalization of old people contributes to their deterioration and hastens the progress of senility. What we are doing now, it is clear, will provoke increasing criticism and pressure on the department for change.

It was a convincing argument. Brittain was given the green light to move forward in developing a full-fledged policy proposal to take to cabinet. Six months later, in early June 1980, a draft proposal was forwarded by Veterans Affairs to the federal government's interdepartmental Social Development Committee for discussion. In his presentation to the SDC Brittain once again underscored the demographic urgency underpinning his department's proposal for a new aging veteran's policy centred around a community-based home care strategy. Over the next five years the veteran population over age 65 would jump by 53 per cent reaching 330,000 and would peak at 455,200 in 1991, more than double the number in 1980. Since geriatric experts calculated that the risk

of losing self-sufficiency 'doubles with each successive five-year age group' past 65, the potential spike in the costs of providing institutional care for the veteran population, were truly alarming.

Our present way of dealing with this loss [of self-sufficiency] since 1924, has been to warehouse the casualties in departmental and contract hospitals. This way is badly outmoded. It does not recognize better ways of helping nor that they have been developing in all parts of the country, admittedly somewhat fragmented and uneven. If we keep on the way we are going, the increasing pressure of need is going to force us into substantial costs to convert acute beds into nursing home-type, whose operating costs are substantially higher than in community-specialized facilities.

The department's alternative was for a 'more effective and less costly way' in meeting this need through a set of programs designed to 'embrace support services delivered at the patient's home.' No longer should treatment of aging veterans be available only within Veterans Affairs hospitals or in designated contract beds. Instead, personal, supervisory, and nursing care would be provided through community facilities. In addition, the proposed Aging Veterans Program would also include the delivery of professional and health-related services in the veteran's residence, as well as home modifications necessary to support his ability to age in place, and social transportation to get veterans to and from out-patient or day hospital facilities in order 'to maintain or restore capacity for self-sufficiency.' The goal was to 'make certain that they live, as long as is possible in their

own homes, in as happy and as healthy a state as can be.’ Eligibility initially was to be applied to all veterans with overseas service or pension entitlement. For veterans with a pensionable condition requiring such care, the department would pay ‘the full cost’. For other overseas ‘entitled veterans and civilians’ it would ‘pay costs not met by provincial programs to the extent necessary to protect income for ordinary needs at the [War Veterans Allowance] level.’ By selectively ‘topping up’ provincial home care coverage for eligible vets, the department hoped to ‘disengage gradually and as opportunity affords from our present direct provision of care at the nursing home level...leaving the actual operation of health systems to provincial jurisdictions.’ In other words, a new engagement in the lower level of home care would allow for a progressive retreat from the higher levels of nursing home care. In any case, since their clientele was aging faster than the general population, the department could not wait for the provinces to improve their long-term care programs. ‘We must anticipate provinces won’t act as rapidly as we need to.’ By including veterans with both pensionable and income qualifications in their proposal department officials estimated that, through their proposed Aging Veteran Program, over the next five years ‘almost 27,000 will benefit in varying degrees’ out of a total of 260,000 aging veterans in these categories, at a total cost of \$153.4 million.

In discussions with Treasury Board and the Ministry of State for Social Development that July, however, the initial reach of the Aging Veterans Program was scaled back dramatically. Treasury officials expressed alarm about the ‘uncertain economic climate’ and the program’s ‘potential for spiralling costs’ particularly for new home care services never before supplied by the federal government, some of which, such as grounds-keeping or home modifications, were simply not available under provincial home

care programs. The scope of the AVP proposal also suffered at Treasury Board hands because it was coupled with the department's requests for 'significant improvements in benefit levels under the Pension Act and the War Veterans Allowance Act' which took higher priority. As a result, instead of a home care program reaching 27,000 clients, the target group for the AVP pilot project over the next four years was scaled back to only 3000 to 3500 overseas services veterans who, regardless of their income, could relate their need for home care services directly to a war-related pensionable disability. Its budgetary allocation was a modest \$21 million spread over this same time period. Since disabled pensioners were 'commonly perceived by veterans organizations to have first call on services' it was not surprising that they became the initial clients of the AVP, especially as their relatively smaller numbers guaranteed lower start-up costs. By using them as a pilot project, the department could 'gain first hand knowledge of the costs and benefits of these services without creating irresistible pressure for immediate expansion of the program.' As Jacques Boisvert, chief of treatment benefits for the AVP when the program was launched in 1980, later recalled:

There was always a pecking order in how benefits came out in Veterans Affairs. And the pecking order generally dealt with pensioners first, pensioners being those who actually suffered some form of war-related disability in service...And then after that you went down the line and got into income dependent veterans...So there were always two streams for all your benefits: pensions and allowances....The first ones off the mark would have been the pensioners, and then, in order to narrow the focus, to be able to control this program, because we

really didn't know where this thing was going to go, the potential was lots of money, lots of need, lots of interest. So you wanted to narrow it down and one of the ways to do that was to link the benefit to a very specific pension condition. So if you were pensioned for something wrong with your legs, and you were unable to walk as result and push a lawnmower, well you had to make that kind of a link: disability to need to benefit. That's the way it started off...I would say it was very specifically because of the pecking order of the traditional way benefits were rolled out with pensioners first. And secondly, to try and control a program where we really didn't know costs- we marketed it as a program that would **save** money.

Nonetheless, the decision to start the AVP by relating eligibility solely to the pensioned condition created tensions within the program between the entitlement created by war and the needs generated by aging which would persist over the next two decades. As Jack MacDonell warned, based on his extensive experience at Deer Lodge Day Hospital, Veterans Affairs medical officers would have 'difficulties...in determining whether conditions [requiring care] are related to pensionable disabilities or not.' Other staff argued that 'AVP benefits are meant to respond to normal aging-related needs. Given that aging can never be considered a pensionable disability, how can this eligibility criterion apply?' The decision was a 'very subjective matter of interpretation', department officials conceded, which would create 'a constant conflict between the [department] counselor...trying to address the need of the client, and the pension condition which was set out by the pension people.' Dr. A.J. Davies, Program Medical Adviser for Veterans Affairs took a similar view. Eligibility for the AVP should be on the basis of need for

assistance and not tied to a relationship to the pensioned condition. 'As our veteran population gets older their problems become more complex and varied and thus difficult to relate to a specific problem. This situation cannot be solved to anyone's satisfaction and is unfair to the veteran.'

Despite the restrictive initial eligibility conditions and small start up population, senior department officials nonetheless argued that the AVP was 'a foot in the door' and that they hoped to 'expand the scope of the program to include all needy veterans and civilians with qualifying service at such future time as the fiscal climate may permit.'

Among district office staff there was 'a strong reaction against restriction of eligibility to disability pensioners, and the need to relate AVP to disability rather than simply to the needs of the aging veteran.' Others expressed 'shock and dismay' or grumbled that the decision to severely pare back its scope was the result of 'perceptions of a clutch of more or less senior functionaries at the centre of the [federal] bureaucracy' who seem to have forgotten that 'even in times of fiscal stringency' veterans programs enjoyed widespread popularity among the general public. Opinion polls showed that sympathy for their clients far outranked support for refugees or people on welfare. 'It is veterans who most Canadians would like to receive more assistance.' Over the next two decades, the department would be proven right.

When the AVP, in its pared-down version, received approval-in-principle from cabinet during the summer of 1980 three goals were defined as critically important if it was to be judged a success. The first was cost avoidance. Money for the program was to be found within the existing departmental budget. Its number one objective was to 'contain the increasing adverse effects of aging in Canada's veteran population more

effectively and at reduced case cost.’ Care in the home would ensure an ‘improved and less costly response to the needs of individual veterans, offset risks of increased federal involvement in the operation of the health care....and facilitate use of emerging provincial extended health care programs.’ The second goal, one which would receive increasing prominence as time went on, was ‘to maintain the self-sufficiency of a spouse whose marital partner requires extended in-patient care.’ Since the wife was usually the veteran’s primary care-giver, ‘her health status is of concern to the Department.’ Relieving some of her burden through contributions for home support or respite care was therefore in the department’s long-term interests. A third objective was to ensure that veterans across Canada had more equal access to personal and nursing care, resources which, at present, were regionally skewed. Of the total of 6600 care beds available to the department only 2400 were suitable for domiciliary or chronic care and these were ‘located in centres where slightly less than half the veterans live.’ As a result, most could get help ‘only at the risk of trauma following separation from family, friends and familiar surroundings.’ A home and community-based care strategy would greatly decentralize the accessibility of support services across the country, although it would also likely uncover even more unmet needs. For every two veterans in an institution, department officials estimated there were three ‘remaining in their homes who need support services to offset diminished capacity.’ At the same time they also estimated that 35 per cent of existing institutional beds were ‘occupied by persons who could continue living at home with modest support services.’ To rely solely on institutions as a response to an aging clientele would cost the department an estimated \$36 million dollars in increased capital and operating costs over the next four years alone, long before the post 65 veteran population reached its expected

peak in 1991.

Veterans organizations, with '650,000 card-carrying members', however, viewed the guarantee of a long-term care bed as 'a virtual right, earned by contributions to the national interest in wartime.' Any perceived attack on this entitlement would provoke a 'quick and unfavourable reaction', department officials warned. The Aging Veterans Program, if successful, offered a way out of this dilemma. Reducing reliance on expensive contract beds 'would likely be more acceptable if offset by...more use of community facilities and home-delivered services.' This would become the key political rationale for AVP.

On November 6 1980, after almost three years of background discussions, the Aging Veterans Program was officially announced in the House of Commons by acting Minister of Veterans Affairs, Gilles Lamontagne. Its scheduled start was 1 April 1981. The program's key purpose, Lamontagne stated, was to provide financial aid 'so that eligible veterans can continue to live independently and comfortably in their own homes. When this is no longer possible, the Department may assist veterans to meet costs of care in a nursing home in their home communities, so that they may be near their families and friends.' Although half of Canada's 800,000 veterans would be over 65 by 1985 the fledgling AVP, Lamontagne stated, was targeted only at those, among the group of 100,000 or so disabled pensioners, whose ability to live independently could be affected by their war injuries. As mentioned previously, department officials estimated that, among this initial group, the AVP would actually reach less than 3500 veterans during its first four years as a pilot project, and no more than 1650 at any one time. Despite its limited scope, they saw tremendous potential for the program in the years ahead. 'With AVP we

have taken the first step towards a health service without parallel in this country,' assistant deputy minister James Smith predicted.

Veterans' claims for eligibility would be assessed by new multidisciplinary health care teams, composed of a doctor, a nurse or other health care professional, a counselor, and an administrative and entitlement officer, to be established in each of the department's 31 district offices. These new teams would 'perform an in-depth assessment of the veteran's environmental, financial, and clinical situation, design a comprehensive intervention program...and assist in the implementation of the intervention plan.' Services to be offered would include 'grounds keeping, home modifications, friendly visiting, meals-on-wheels or wheels-to-meals, homemakers, nursing assistants, nurses, physiotherapy, occupational therapy, attendance at day hospitals, day care,' and when this was no longer enough, the veteran would be 'assisted in obtaining admission to an appropriate institution in the community of his choice.' The goal was to 'keep the veteran as independent, active, and in the community for as long as possible and proper.'

The provisions for housekeeping and groundskeeping, under the category of home care services, were particularly trail-blazing and embodied one of the key insights of program advisors Sir Ferguson Anderson and Yetta Gold (of Winnipeg's Aging and Opportunity Centre) namely that preserving the dignity of the elderly was essential to their ability and willingness to live independently. As Darragh Mogan put it, 'People can be sick as all hell, but if their dignity in the community is maintained, in other words if they maintain themselves more or less to the standard of the community, they'll do a heck of a lot to stay home. If the surroundings and environment begin to fall apart, they will too. They'll give up. Both Yetta and Ferguson Anderson really stressed that. Hence the

groundskeeping, housekeeping element which are by far the most popular components of the program, even now.'

Under AVP regulations, the program would pay for 'housekeeping and groundskeeping services including all those domestic duties and chores necessary and incidental to a) the upkeep of a home or domestic establishment on a day-to-day basis, and b) the maintenance of lawns, flowers, and vegetable beds, shrubs, hedges, and trees and the removal of leaves, debris, ice and snow from the walks and roadways of a home or domestic establishment.' No provincial home care program then or now provides an equivalent service. The AVP assessment model borrowed heavily from Jack MacDonell's team-based assessment process pioneered at Deer Lodge. Almost all of the 14 treatment services which would be available twenty-three years later were present at the program's creation. For those disabled pensioners who qualified, the AVP would provide up to \$45 per day for adult residential nursing home care; \$4300 per year for home care, \$500 per year for ambulatory care, and \$2500 per year for home modifications. The program's emphasis would be placed on personal choice, independence and community living. As one of the first publicity brochures for the AVP put it, 'Veterans Affairs aims to help you to carry on and improve your way of life. This will allow you to live in your own neighbourhood - if possible in your own home - in as happy and healthy a state as possible...Since the program is a voluntary one, your agreement is needed and you may decide at any point to drop out of the program.'

Between Lamontagne's announcement in November and the April 1981 start date the AVP pilot project implementation team, spearheaded by Darragh Mogan, criss-crossed the country meeting with regional and district offices to finalize details of the program. An

AVP pilot project was also launched out of the Kingston district office to test some of the proposed delivery strategies. A number of issues of particular concern arose as the AVP moved closer towards implementation. The first was training for district counselors. The original cabinet proposal estimated that the AVP would generate possibly a 20 per cent increase in workload over the next five years. The hope was that this could be contained without any increase in actual staffing levels through training in gerontology and geriatrics and by improvements in 'systems and procedures'. This expectation posed large challenges for district counselor staff, many of whom were veterans themselves with little training in the casework and gerontological assessment skills which would be required by the AVP. As Duncan Conrad, former chief of training and standards for the department explained:

In those days...the area counselor's job was to fill out applications...and monitoring to make sure there weren't overpayments...For the most part [they] really went out of their way to look after clients and to provide services to them. But the expectations were that you were going to complete your annual reports [and]...make sure that the clients were really meeting the needs as dictated by the department in terms of eligibility standards...[Many saw the AVP] as an additional burden. Something that was being added on to an already full workload. Many of them felt...poorly equipped to deal with the kinds of things we were asking them to do....We were asking them to take some of their already full days and to add to that this very intricate and complicated team process in which they would have to, instead of working independently in their own area, work with a nurse and a team

and go through a very complex process for them. And so I think that a lot of them felt threatened by that process. A number of our managers felt that they wouldn't have the resources to do it and that the resources they did have were really not skillfully equipped to do what we were asking them to do.

The department did propose to develop a 'National Training Perspective' for district counselor staff in order to meet the anticipated needs arising from the AVP. Given the newness of the skill sets required of Veterans Affairs staff and their supervisors, it started with an eleven day 'Training the Trainor' workshop. The initial reaction 'ranged from cool to hostile' but over time the process improved with the development of a 'reusable training package.' The second phase was 'on the job training' to provide staff with 'individual and team skills in the nuts and bolts of team work.' A third phase, down the road, provided access for district counselors to university and college gerontology programs in order to promote the 'acquisition of sensitivity and skills in the counseling of older clients'. These opportunities would prove far more popular. As one staff member at that time recalled:

It took us a long time to get to the point of looking at the person first and the benefit later. But it was a clearing house for a lot people. And for those that didn't want to leave...it was just paradise. You kind of fell into two categories, ones that just wanted to do the bureaucratic work, and they didn't like it at all and cleared out. But some, they just loved it. We sent them on gerontology training. I took it for a while myself. It was offered to people at head office too so that we gave

people an opportunity to change. If they didn't have a social work background, we gave them training in the elderly. That was back when the elderly were the focus of our attention. And counseling too. Excellent professors. The courses I took were law, institutional care, psychology of the elderly. There were all kinds of different courses.

Regional offices within Veterans Affairs expressed concerns about 'maintaining work output while people are undertaking training.' 'How much additional workload can be absorbed and in what frame before there is a drop in productivity as it applies to other traditional areas of service? Frankly we don't know....We are some time away from being able to develop and implement procedures and work patterns that will free up substantial amounts of counsellors' time, if indeed this will be possible,' one regional director pointed out. Others were concerned about convincing district counselors to buy into the program. 'That caused a few hiccups,' Jacques Boisvert recalled. 'Obviously when you are making a shift in hiring practices you have a lot of people who are already on board. It cut off a lot of avenues that people had hoped to aspire to. People who were within the department and had aspired to become counselors in the traditional manner were sort of cut off. And so that created a bit of heartache...But it certainly did bring in a lot of more qualified counselors across the country over a period of time.'

Five other issues also surfaced in the discussions around the AVP prior to its April 1981 implementation date which would continue to resonate throughout the next two decades, and so are worth exploring here. The first was a somewhat fractious discussion with the Canadian Pension Commission to resolve a key area of duplication between

disabled pensioned veterans receiving an 'Attendance Allowance' through the CPC to help defray the costs of personal home care and similar provisions to support personal care in the home which would be delivered to disabled pensioners through the AVP. The tasks of personal care were similar and in many cases applied to the same veterans, but the underlying philosophy and methods of payment between the two programs were quite different. The attendance allowance, which dated back to World War 1, was an entitlement which provided a monthly cash payment from the CPC to disabled veterans which could range from \$78 to \$489 per month, depending on the degree of their injury. In theory the money was to be used to purchase needed personal care to assist them in the activities of daily living in their own homes. In practice, particularly where there was already a spousal caregiver or family member in place providing this labour at no cost, the money often was viewed as simply a direct supplement to family income. The AVP, in contrast, was a contribution, or conditional grant, paid by Veterans Affairs to veterans for specific home care services which had to be delivered and for which receipts were required in return for payment.

Within Veterans Services the degree of overlap between the AVP and the CPC's Attendance Allowance came as somewhat of a surprise to some senior officials. 'I cannot accept that identical services be provided under two separate acts,' assistant deputy minister James Smith complained to his officials upon learning of this duplication from the chairman of the CPC. 'Please tell me that I have got my facts wrong and that, in developing [the AVP] we liaised with CPC and are fully aware of the benefits contained in their Act.' Since the AVP was the 'broader' program, a logical solution would have been simply to incorporate the 'attendance allowance' within it, thus avoiding any duplication

of services or payments. However, this ran against the territoriality of the Canadian Pension Commission and the financial interests of veterans already in receipt of the AA. To deduct AVP home care costs from the lump sum monthly entitlements already being paid out by the CPC could leave some individual pensioners with less than \$10 remaining out of their previous \$300 to \$400 monthly attendance allowances. As CPC Chairman A.O. Solomon tartly asked, 'will [we] tell a veteran that for his own good we will reduce his income, but arrange for someone to come in and give him a service, such as...a bath or doing his laundry or cleaning his living quarters? It is possible that the veteran (and his wife) might prefer the extra income and forego a weekly bath or be content to live the way he does.' Nor would veterans' organizations, protective of pension entitlement claims, likely contemplate such a change with equanimity. As Jacques Boisvert, chief of treatment benefits for Veterans Services at that time later recalled, 'after long and sometimes pretty bitter discussion it was made very clear to us that regardless of what we thought as duplication, we were not going to be touching that program. We would have to design our program around...the Attendance Allowance in some other way. So that's what we did. It wasn't a matter of choice.' As a compromise, it was agreed that veterans in receipt of Attendance Allowance could receive up to one day a week of housekeeping services, plus one additional week of homemaking care a year, provided through the AVP, in order to 'give the wife some respite from her duties.'

A second issue was deciding how to monitor consistency in administering the AVP within the five regions and 31 districts which made up the administrative structure of Veterans Affairs. Since veterans were a national responsibility, there was a clear need for establishing national standards for delivering the AVP. However, provincial home care

services which the AVP was designed to 'top up' varied dramatically from coast to coast ranging from almost none in the four Atlantic provinces to rapidly developing home care programs in Manitoba and B.C. Who would decide what needed to be done in setting and monitoring the consistency of standards in delivering the AVP at the district level? 'Head Office felt strongly that [they] should have this responsibility...Regional Office felt just as strongly that this was [their] responsibility.' For the time being it was agreed that 'by leaving implementation strategies to the Regional Directors...there would be the advantage of reinforcing the notion that differences between provinces necessitate individualized approaches to implementing AVP.'

But this approach also raised concerns at departmental headquarters among those central to the program's original design. 'Unfortunately I am beginning to pick up a theme that all standards of operation should vary from region to region, perhaps even district to district,' Darragh Mogan complained. 'While this in DVA has a lot of historical validity, it is the very mire of inconsistency we are attempting to escape from...In my view there must be meaningful standards of process...Such standards assure a consistent, evaluable program that can meet its national objective.' Assistant Deputy Minister R.C. Adams agreed. As he reminded regional directors, 'differences among provincial and local services, aging patterns, geography and historic expectations all complicate our task and must be taken into account. But we must bear clearly in mind that we are operating a national program.' Tensions between regional and national perspectives in delivering the AVP would remain an ongoing concern within the program over the next two decades.

Related to this issue was the question of monitoring outcomes for the delivery of 'safe, efficacious, and high quality care' to pensioners now that Veterans Affairs was

moving 'from a position of direct delivery of care and treatment...to an indirect involvement.' A special background study commissioned on this theme concluded that any attempt to develop direct monitoring or regulation of service provision through the AVP was unfeasible. Even at the provincial level 'the development of home care standards is still in its infancy.' Since wherever possible the AVP would be topping up such provincial services, the best it could hope for was simply 'to accept completely the existing provincial standards of care.' National monitoring of service delivery was also antithetical to another key principle of the program: that veterans would self-manage, as much as possible, the contracting of their own services. It would also 'go against the [department's] and Federal policy of decreased involvement with direct delivery...of health care.'

A fourth issue was deciding how strictly to interpret the relationship between a pensionable disability and the need for AVP, a dilemma at the heart of tensions between war-related entitlement and human need within the program. During planning meetings prior to launching the AVP it was agreed that the program would be available 'only to disability pensioners who required aid because of their disability *and related conditions*.' This could be a difficult judgment call. As Jack MacDonell pointed out, there would always be problems in "determining whether a 'condition' was related to the pensionable disability...'Related' means any condition that is found to be present." If this were the case, MacDonell warned, the AVP might well 'cost a great deal more than has presently been allocated.' Other staff complained that the exclusive focus on disability 'medicalized' the entire approach of the AVP since it applied to health conditions only. 'That means an interest, quite exclusively for the health professional...The multidisciplinary team

becomes in spirit and in terms a multidisciplinary one: the Health Care Team.’ Why not simply call it the ‘Pension Veterans Program’ if social needs related to aging were not the first priority?

A fifth controversy would arise over the decision, made at the outset of the program, to provide veterans eligible for the AVP with access to the full range of treatment benefits such as eyeglasses, hearing aids, dental care, and drugs, which were already available to veterans receiving institutional care. The decision was intended to remove any economic incentive for veterans to choose domiciliary over home care. ‘On the surface this proposal appeared to be a real seller and was received with great enthusiasm by most of the [Head Office] and field personnel who reviewed it,’ Jacques Boisvert, chief of treatment benefits pointed out. But he, along with others, wondered whether the department could ‘justify paying for a veteran’s dentures or possibly even greater expense like home modifications as a result of the fact that we are paying contributions only on the basis of providing housekeeping or groundskeeping services?...What are we opening the door to if we take a look down the road at extending the program?’ Soon after the AVP began, some of Veterans Affairs financial watchdogs in Ottawa also implied that the department had attempted to “‘sneak one by’ by hiding this treatment rights provision” in the general regulations rather than ‘highlighting it.’ Darragh Mogan objected strenuously to this implication:

We were, at least sufficiently ‘up front’ with central agencies to provide them with an estimated cost of the treatment rights provision - they did not, as I recall, quibble with either the amount or the concept. So far as the thinking behind such a

proposal went, we did examine possible means of offsetting the potential problem, i.e. 'getting a walk swept' as a backdoor route for full treatment eligibility...During discussions on this matter it became apparent that it was an all or nothing situation given the requirement to establish equity... In addition, the AVP assessment process... hopefully eliminate[d] any possibility of using AVP contributions for other than their intended purpose....As many as five to eight different individuals would have to agree on the contribution arrangement before it [could] be consummated.

Despite Mogan's assurances, the use of AVP and subsequently VIP by veterans as a backdoor into treatment benefits would remain an ongoing issue. As another senior staff member within the department recalled, "in many cases what people wanted [was] not [AVP] but treatment benefits. It was a gateway...It didn't take very long to figure it out: 'I don't really need somebody to do my housekeeping but I sure would like somebody to pay for my glasses, my dental and all the other benefits that follow.'"

NOTES

Chapter 2

THE AVP 'PILOT PROJECT' 1981-1983

During its first two years of operation the Aging Veterans Program was characterized as a 'pilot project' by senior officials of Veterans Affairs. This description aptly captured a number of constraints under which it operated. The most important were its highly restrictive eligibility conditions as a program targeted only to disabled pensioners rather than to a wider pool of overseas service veterans as the department had originally recommended. This narrow client base estimated to reach no more than 3500 veterans over the AVP's first four years reflected, as previously argued, the traditional hierarchy surrounding veterans' rights in which disabled pensioners, although "not [the] veterans in greatest need...historically had the political 'first call'" on any new benefit program. More importantly, it also was linked closely to 'serious reservations' within the central agencies in Ottawa as to whether the Veterans Affairs could control the AVP's costs. As Deputy Minister Bruce Brittain told a Legion convention two years after the program began, 'in obtaining the initial authorization for a limited program it was abundantly clear that Treasury Board and the Social Policy Committee Secretariat were not at all convinced that we could reasonably accurately forecast costs; could control costs; and could estimate the take-up rate for such a program.' Darragh Mogan was blunter. When asked, years later, whether central agencies initially believed that AVP could be a cost effective alternative to institutional care he replied 'They never believed it. Absolutely, never, never. They thought it was just a boondoggle. And that bedeviled us. That attitude has changed. But

there was a belief, a very very strong belief, almost a preoccupation with the fact that the VIP should be gutted, that it was a joke.’

The knowledge that the AVP was under intense Treasury Board scrutiny created a climate of caution and fiscal restraint among program administrators in its early years which led to tensions both within departmental headquarters and among the five regions and 32 district offices charged with interpreting and delivering the new program. Since low income WVA recipients rather than disabled pensioners had the ‘greatest demonstrated need for AVP services...by virtue of their age, health and poverty level,’ the department’s top priority from the beginning was to win approval for extending eligibility for the program to them along with other overseas service veterans as soon as possible. Central agency approval of this expansion, however, would be contingent, over the next four years, on keeping AVP expenditures and caseload forecasts strictly within previously approved limits. As a result, publicity for the program was deliberately kept ‘low profile’ in the program’s first two years so as not to encourage more applications than the department could handle or fund. The first reference to the AVP in the Legion magazine, for example, did not occur until January 1982, well over a year after the program was announced in the House of Commons. The first advertisement by Veterans Affairs for the AVP in the Legion was not placed until July 1982. When field staff complained about the absence of publicity, senior officials commented privately that ‘the fundamental fact which we clearly cannot tell the field, is that we wanted to avoid publicity and went to great lengths to do it.’

As a result, the initial take-up rate for the AVP - only 275 recipients in its first year - was far below the target of 1000 forecast in the original proposal. These low numbers

drew unfavourable attention from the Opposition benches in Parliament. According to department officials the key factor explaining the program's low take-up was not lack of publicity so much as the 'narrowly defined eligibility criteria' of the AVP itself which limited applications only to disability pensioners who could prove that their need for help in living independently was related to their war disability. The program was 'so constrained as to be almost non-existent,' assistant deputy minister James Smith complained eight months after it had begun. 'In practice it has been nearly impossible to help veterans who require AVP type of services due to their pensionable disability...[T]he present program is not achieving its objective.' Other staff pointed to an almost complete lack of coordination between the Canadian Pension Commission and Veterans Services in promoting the AVP as another factor reducing applications. 'After all, the clients *are* disability pensioners.' Management also found it 'difficult to develop any enthusiasm for the AVP' among district counselors who 'despite training and briefings felt they were being asked to discuss a program and benefits with clients without being too specific and without commitment.'

Since veteran apathy was as threatening to the AVP's future as potential cost over-runs, department headquarters soon reversed direction and instructed regional offices and district counselors in the fall of 1981 to pursue a vigorous program of what department officials termed 'ascertainment.' As the program's chief medical advisor put it, 'since they may not come to us, we will go to them.' The original idea of ascertainment, or a 'deliberate, pro-active, out-reach strategy,' was developed months before the AVP even began by Darragh Mogan and Don Coates at head office. They argued the Veterans Affairs should seek out 'high risk veterans who would not normally come to our attention

and therefore not normally receive health care and/or social and economic supports.’ Early detection and treatment of their needs would forestall higher institutional costs down the road. It would also provide the department with a unique research opportunity since no other branch of government in Canada was doing this kind of outreach work among the elderly. Initially designed as a strategy of prevention and education, ascertainment soon became a tool for boosting the numbers applying for the AVP. As Duncan Conrad recalled:

Because the project wasn’t being embraced as we thought it should...we went to our district offices and said, ‘look, we know these needs are out there, people are not coming back, so we want you to go to them....You need to go out and...’beat the bushes’ to make sure that these folks are being identified. And so we did go out and do a lot of ascertainment and generate an interest. And it was like a snowball. Once it gets going, you have a difficult time trying to control it. So much so that we got an overwhelming response to the process to the point where a number of offices that had really embraced it, weren’t able to handle it.

By the end of AVP’s second year caseload numbers of 1400 were actually slightly above the projected target and by the third year they had more than doubled to 2924, the anticipated ceiling for the original pilot project phase.

This rising caseload, however, brought with it a growing sense among district counselors and senior officials within Veterans Affairs that, in some cases, the wrong people were applying for the wrong reasons. The key economic rationale of the AVP was

to reduce the demand for domiciliary care in contract beds funded by the department. A large proportion of veterans seeking admission to these facilities had low incomes and were attracted by the low monthly fee of \$120 which had remained unchanged since 1949. However, AVP applicants were not being drawn from this group. Instead, 'the bulk of the clients seen,' department staff reported, 'were well off financially and in the main very independent', a result which caused consternation among senior officials. 'The impetus for AVP was to make it possible for more and more of the disabled veterans who were also poorer and aged to remain at home rather than to stay in an institution,' program medical advisor Dr. Bill Robertson observed. 'It was not...meant to provide free groundskeeping services for better-off disabled pensioners who...may be finding that the existing AVP provides them with the opportunity of what in effect is a veterans' perk rather than a basic necessity.' One year into the AVP, deputy minister Bruce Brittain joined the debate by expressing his alarm over payments for 'peripheral' services such as grounds-keeping. 'If because of the principle we must pay for grass-cutting for a millionaire then we should seriously re-examine the whole question of payment for services that are not narrowly, perhaps, directly socially or health related.'

At the heart of this unease with the AVP's early direction lay two key issues which would by no means disappear throughout the program's history. The first was whether the AVP should be seen as an entitlement for disabled pensioners, regardless of their income, similar to other benefits paid through the Canadian Pension Commission. The second was whether or not housekeeping or groundskeeping services, in and of themselves, were essential to promote the 'self-sufficiency' of the veterans. The entitlement dilemma flowed directly from the fact that the AVP, in its pilot project stage, was restricted only to

disabled war pensioners and therefore could easily be viewed as simply another income supplement, similar to Attendance Allowance. 'In DVA...over the years we have been pursuing a policy of providing every available benefit to CPC pensioners regardless of their assets,' senior officials pointed out. The Aging Veterans Program, however, represented the opportunity to promote a 'radical change' in this philosophy. 'AVP is not a matter of right, it is a matter of need, and the need is very much individual in nature,' Darragh Mogan argued at the end of the program's first year of operation. Veterans organizations had to be dissuaded from mounting 'an endless stream of pressure...to mak[e] sure that each individual gets absolutely everything possible from the program.' Other colleagues at departmental headquarters agreed that to run the AVP as an entitlement-driven program would defeat its key objective. 'The challenge is to get this across to the Veterans Organizations and to our own staff - if each benefit or service is not one which is judged as needed, provided only as long as needed, and tailor-made for that veteran then we will have failed, and may well create dependency where self-sufficiency existed before.'

Housekeeping and groundskeeping services became the target of this debate. By the second year of the AVP they represented 93 per cent of the home care support agreements provided through the program, a 'rather startling statistic [which] should cause one to retreat back to square one and to re-look at the intent and philosophy under which the AVP was conceived', Jacques Boisvert, chief of treatment benefits for the department warned. Largely as a result of the success of their 'ascertainment' efforts, Veterans Affairs district offices were now facing an 'onslaught of requests' for these services coming from veterans with pensionable disabilities who were 'full-time employed

and functioning independently.’ Since they were not in danger of needing institutional care, and often were not receiving any other health services, why should they receive financial help in cutting lawns, shoveling driveways or cleaning out their eave-troughs? Was this not ‘fostering dependency’ rather than promoting ‘self-sufficiency’, some department officials asked? Would such generosity not also ‘endanger the credibility of the program’ with central agencies and therefore compromise the likelihood of it being extended to include a much wider pool of low income overseas service veterans once it moved beyond the pilot project stage? What irked some department officials most was channeling funds to pensioned veterans who, if they needed help only for house or grounds-keeping services, could easily afford to pay for such services themselves. However, they also knew that any attempt to subject these services to an income test ‘would create political pressure which would be unbearable’ from veterans organizations which viewed any pensionable benefit related to a war injury as an earned right regardless of a veteran’s standard of living.

To get around this dilemma, while still keeping a lid on costs, senior staff within the department decided to clamp down on the health criteria governing access to the most popular housekeeping and grounds-keeping services provided through the AVP. During the early summer of 1982 a memo was sent to all district offices noting that henceforth housekeeping and grounds-keeping could be provided only to veterans who were also receiving some other health-related services through the program. This decision provoked an angry backlash both from both veterans’ organizations as well as from the department’s own regional and district offices. The War Amps of Canada pointed out that many of their members getting these services did not need more medical help but did require assistance

with some of the more demanding physical tasks of maintaining an independent household. To remove support for housekeeping or groundskeeping to these men was a 'drastic retrenchment.'

Veterans Affairs regional director for Ontario, Don Ferguson, also reported that this decision by department headquarters, undertaken without consultation with staff working in the field, had "caused a 'ground swell' of confusion, disappointment and in some cases out and out anger amongst our regional/district staff.' In the first place, within Ontario it would result in the cancellation of over 80 per cent of the AVP agreements currently in place after his counselors had just been encouraged, through the ascertainment process, to go out and 'beat the bushes' to locate unmet needs among their clients. Secondly, most pensioned veterans receiving housekeeping and groundskeeping services were already getting some other form of professional or semi-professional support through other Veterans Affairs programs unrelated to the AVP. Finally, nothing in the original regulations creating the program stated that home supports took second place to medical treatment in terms of fostering veterans' independence. In an angry message sent to department headquarters in Charlottetown Ferguson pointed out that:

In recent months, managers and staff have really taken hold of the AVP, triggered by such catalysts as our Gerontology Training Program; staff are aware of [Veterans Services'] desire to expand the program in the not too distant future; staff and veterans groups have read speeches made by our Minister...emphasizing the AVP, and especially the provisions for home support services. Suddenly the June 24 memo arrives which appears to be heading the Aging Veterans Program in

a totally opposite and quite negative direction...I have personally received a telephone call from each of my [District Directors] several [Senior Treatment Medical Officers], Dr. Fisher and several Veterans groups, all conveying the same message...'How can something like this be taken away?' ...[We are] not saying ...that there may [not] be a need to tighten up our controls. But...surely there was a better way to handle this most important issue that would have avoided the confusion and negativism that has been created...In my opinion [it] did little to enhance HQ and field relationships and the field's image, especially at the [District Office] level, about HQ's understanding of client needs.

Taken aback by this fierce opposition, Veterans Affairs headquarters rescinded the decision that autumn. Veterans would not be required to receive some other health-related service in order to qualify for housekeeping and groundskeeping support through the AVP. However, they would have to be judged by District Health Teams to be in need of assistance in the tasks of daily living. Whether that help came from family members, professionals or others, the degree of assistance would have to be equivalent to what was required for admission into Type 1 or Type 2 domiciliary care facilities. This decision also provoked a strong reaction from counseling staff. What about a one-armed amputee 'apparently self-sufficient in all areas of daily living except where he requires assistance to shovel his walk and driveway in winter?' This type of veteran did not need residential care. Yet he was exactly 'the kind of person we indeed wish to assist...[B]y helping in this one area we are in fact helping him to maintain his strengths thus helping him to remain independent.'

Veterans Affairs headquarters refused to authorize blanket approval for AVP services to veterans in any particular category, such as amputees, arguing instead that each situation had to be judged, on a case-by-case basis, according to the degree of individual need and whether or not providing AVP services such as groundskeeping or housekeeping would allow the veteran to remain 'self-sufficient.' It was a process which continued to produce divergent outcomes across the department's five regions. Senior officials also conceded that, because of the close association of war-related disabilities and benefit entitlement, it would be 'difficult to meet the ideal with the present pensioner group.' They hoped this problem would diminish once the AVP was extended to a much wider constituency of low income veterans.

The attempt, between 1982-83, to control AVP costs through tightening the medical criteria for eligibility also alarmed some senior officials who worried that the program was in danger of losing its social vision after only two years of development as a pilot project. From its inception the AVP had been pulled in two directions, one medical and the other gerontological. For some individuals in Veterans Affairs such as assistant deputy minister James Smith and program medical advisor Dr. Bill Robertson, the AVP was primarily 'a medical program [whose] key persons...are the Senior Treatment Medical Officer and the nurse.' This medical bias permeating the AVP was confirmed by an internal 10 per cent sample of all cases on file between April 1982 and March 1983 which revealed that, despite the supposedly multidisciplinary composition of the district health care teams, 'only seven per cent of recommended interventions were social in nature.' As the authors of this study concluded, 'it appears as though Health Care Teams could be taking a restricted view of the problems of aging and what can be done to

ameliorate those problems.’ Don Coates, chief of counseling services for the department, was blunter. He warned that the holistic team-based model of the AVP, animated by the ideas of Sir Ferguson Anderson and Dr. Jack MacDonell, was in danger of being lost.

AVP is good stuff. As it was originally conceived and developed ‘health’ was defined in a way that everyone can relate to (and everyone had a piece of the action) and we put ‘health’ care teams in place to assess and deal with client’s ‘health’ care needs. Somehow much has been lost in the translation from idea to action. A very rigid medical model has quickly evolved and the concept of ‘health’ has been altered radically....If AVP will form the bulk of our future activities and if it continues to be overwhelmingly medically focused, where is the place for counseling?...The [District Office] of the future will only have a Dr. and some nurses. There is an AVP infrastructure being put in place now which supports very strongly the tendency that this department has to focus on benefits and pay lip service to services. The reason that no-one can get a handle on the need for case management, accreditation, counselor and supervisor qualifications, counselor orientation, etc., is because, in their view, we do not need all of this [stuff] in order to process and provide medical benefits. It simply does not fit in with the vast majority of opinion in this department. In short, if counseling has no place in AVP then counseling has no place in the DVA of the future.

Darragh Mogan agreed that the study of AVP case files was a ‘sad commentary’ but one which was ‘coming at a good time’ because it highlighted a key issue, namely, ‘who

should quarterback AVP extension?' For the reasons Coates had outlined, his own 'firm, firm view, based on the agony of error in the past, is that project management must be by a layman.' If AVP was truly about preserving the independence and self-sufficiency of the veteran, the creeping medicalization of the program had to be reversed.

NOTES

Chapter 3

EXTENSION OF THE AVP

Planning for the extension of the AVP to a much wider veteran clientele began even before the initial pilot project was launched in April 1981. From the beginning Veterans Affairs officials acknowledged a paradox. As mentioned previously, although 'elderly War Veterans Allowance recipients have the greatest demonstrated need for AVP services,' for reasons of cost control they were 'not currently eligible' for its benefits. Bringing this cohort of needy aging veterans within the reach of the program before they began to generate significant demands for institutional care was therefore the top priority for senior department officials who now viewed the AVP as 'the basis of our health care activity for the future.' In September 1981 Darragh Mogan and Stu Tubbs, both of whom were instrumental in the design of the AVP pilot project, were handed the task of developing an initial review of possible models for extending the AVP to a wider range of veterans. Mogan warned that there would be 'roadblocks a plenty...to an early extension of the program.' Given the 'very severe restraints' surrounding the government's entire envelope for social spending, gaining support from the central agencies in Ottawa for a major new veterans' initiative would not be easy, particularly in light of the Treasury Board's initial skepticism over the department's ability to contain the costs of the AVP. To win cabinet approval any proposal had to be 'credible from the standpoint of cost estimating and control.' Unfortunately, there was not a lot of reliable information to go on. Although the ostensible purpose of the AVP pilot project was to give Veterans Affairs the information it needed 'to refine unit costs and field operations with a view to expansion of the program

to other veterans,' in reality eligibility had been limited to such an exceptional category of veterans that the project was almost useless for predicting future costs once the program was extended to a much broader constituency. As Jacques Boisvert later recalled, "we were really 'blue-skying'. We didn't have any factual information. It was a very difficult thing to predict because you didn't have a whole lot of information anywhere else."

Veterans Affairs officials planning for the program's extension agreed that, ideally, 'the solution of choice would be the immediate inclusion of all persons for whom the Department has responsibility for all client services and client contribution areas.' Given the climate of fiscal restraint and ongoing uncertainty over estimating program costs, however, this was 'not...a realistic expectation.' Instead, the best chance of winning the consent of central agencies for liberalizing the program, particularly in light of their initial criticisms of the AVP that "much of our data was 'soft'," was through a series of extensions which could be 'phased in over time to various groups of veterans. This would allow the program to be initially lower cost and would afford more reliable experience in program control.' Unlike the AVP pilot project, however, new recipients for an extended AVP would be dealt with on the basis of 'treat[ing] the greatest needs first.' In November 1981 Dr. Bill Robertson, the program medical advisor, was put in charge of a larger committee 'to fully review the current Aging Veterans Program and to put forward proposals for its extension' with a goal of reporting no later than June 1982. Robertson was instructed to undertake a 'broad-based consultation with professionals in the field of aging,' as well as with the provinces, and department field staff.

The interim report from Robertson's committee, completed in May 1982, did indeed reflect wide consultations with leading gerontologists and geriatricians across

Canada as well as regional representatives within the department. It recommended a phased-in extension of eligibility for the AVP to overseas service veterans through a process lasting anywhere from three to six years, depending upon the exigencies of fiscal restraint. The key purpose of the AVP, Robertson's committee argued, was to reduce the demand for institutional care. Since all overseas service veterans in need were eligible for domiciliary care provided through Veterans Affairs, by the same logic they should also all be eligible to apply for the AVP, and the sooner this was accomplished, the better since measures "delayed too long...might 'miss the boat' in terms of answering the need" of a rapidly aging Second World War veteran cohort. Such an expansion would increase the client pool from 101,539 pensioned veterans (of whom less than 3000 were actually receiving the AVP) to a total of 265,237 'service eligibles' who by reason of pensionable war injury or inadequate income were currently eligible for Veterans Service benefits. To the list of existing AVP contributions elements which included nursing home and domiciliary care, home care, ambulatory care, and home modifications, the report also recommended adding five new benefits: transportation for a social/physical/mental health-related need; functional aids for assistance in the activities of daily living; home repairs vital to the structural integrity of the residence; safety aids; and relocation expenses to cover the cost of moves within the client's community which were beyond his or her control.

Different ways of phasing in an extended AVP included 'offering a complete package of contribution elements to limited categories of eligible veterans or a limited number of prioritized [sic] contribution elements to all categories of eligible veterans or some combination of both.' The report's preference, on the grounds of 'fairness', was to

offer all existing AVP benefits to the complete pool of service eligibles and phase in the five new recommended benefits over a three year period. However, it had as yet no detailed financial models available to compare the impact of different phasing-in options. The overall costs of extending the AVP, however, would be controlled by the establishment of priorities for eligibility, defined as 'the elderly' (veterans over 65); those 'most in need' according to illness and low income; and 'the handicapped'. Their entry into the AVP would be screened through three 'access gates': overseas service in a theatre of war; the need for assistance in the tasks of daily living, as determined by a Veterans Affairs counselor or health team assessment; and an income test which established their eligibility for a War Veterans Allowance. Only disabled pensioned veterans would continue to be exempt from either age or income-related eligibility screens.

Since the department was only minimally involved in the direct delivery of 'care service' expanding the AVP, the Robertson committee report pointed out, was 'totally contingent on the willingness and ability of care-providing provincial, federal, municipal and private resources' whose efforts the AVP would 'top up.' However, this was 'not a one way street.' Veterans were significantly older on average than the Canadian population. Through working with the AVP these agencies would 'gain a preview...of the expected general population requirements of some twenty years later.' The committee also warned that expanding the AVP would not eliminate the need for continuing provision of institutional beds for aging veterans. 'Community bed access and support is an inescapable and inevitable part of the program. Simply put, there will inevitably be cases where it is no longer possible to maintain individuals in a non-institutional environment', a need which would 'become more prevalent with advancing age' of the veteran population.

Robertson's committee, however, was not the only body scrutinizing the AVP. When the pilot project was first implemented in 1981, Veterans Affairs officials assumed that, because the program had only been in operation for over one year, it would not require an independent evaluation prior to bringing forward a proposal for extending its benefits to a much broader and needier category of veterans. They were mistaken. During meetings with Treasury Board officials in February 1982, deputy minister Bruce Brittain was surprised to learn that 'before any proposals for expansion of the program were presented' an in-house evaluation of the performance of the AVP pilot project, done according to central agency criteria, was 'essential.' It would require at least four to five months work 'in close collaboration with representatives of the Ministry of State for Social Development, the Office of the Comptroller-General and Treasury Board.' As a result, the department's original plan for gaining cabinet approval for implementing an extended AVP by January 1983 was thrown off the rails.

Over the next six months a team led by David Weir of the Directorate of Policy, Planning and Evaluation of Veterans Affairs, aided by two private consultants and detailed guidelines supplied by the Office of the Comptroller General, conducted an independent evaluation of the AVP parallel to the in-house work being undertaken by the Robertson's committee. Their report, released in December 1982, although generally supportive, contained criticisms and recommendations which drew the ire of senior officials in charge of the program.

Caught up in the confusion of relocating Veterans Affairs headquarters from Ottawa to Charlottetown as well as the regionalization of administration within the department itself, the AVP pilot project, the DPPE report argued, suffered from a rushed

implementation, cumbersome and inconsistent administration, lack of clarity around key goals and objectives, poor communication between head office and field staff, the absence of reliable instruments for managing information and assessing outcomes, inexplicable geographic variations in take-up rates, and a potentially costly duplication of existing provincial services. Although the program technically started in April 1981, most district offices were not ready to implement it 'until some months later.' Six out of 31 districts of Veterans Affairs or twenty per cent of the total, accounted for over half of all AVP clients. Two districts, inexplicably, had no clients whatsoever. A number of district offices, the report concluded, likely were reluctant to promote the program until they were assured they had sufficient new staff to run it.

The restriction of the AVP to only disabled pensioned veterans also caused many other field staff to 'question the appropriateness of a program which was promoted...as being intended to meet the needs of aging veterans, while excluding those aging veterans whom they perceived as having the greatest needs.' Staff were confused about the duplication between the AVP and other veteran treatment benefits. They also questioned 'the predominance of health professionals in team decisions and an apparent health bias' which seemed to pervade what was supposed to be a 'multidisciplinary program.' The DPPE report also found 'skepticism' among both head office and regional officials over the predominant role of housekeeping and groundskeeping benefits. These two services accounted for 80 per cent of the contribution agreements and 60 per cent of the cost of the AVP, yet some officials interviewed by the DPPE evaluation team wondered to what extent groundskeeping in particular 'may have been authorized in some cases as a means of qualifying veterans for health benefits relating to non-pensionable conditions', or in

other words as a 'backdoor' gateway into full treatment benefits. Along these same lines, the report also questioned whether Veterans Affairs field staff truly understood that the primary objective of the AVP was not simply to 'promote the self-sufficiency of eligible veterans' but also 'cost containment through employing alternatives to domiciliary care.' Field staff interviewed by the project team seemed to 'demonstrate a philosophy of client advocacy' and 'none...indicated that staving off institutional care was a concern of theirs' leading the authors of the report to conclude it was 'evident that the objectives of AVP have not yet been clearly defined for purposes of program administration nor explicitly communicated to all field offices.'

Indeed they discovered that 'discontent with both format and content' of instructions from department headquarters 'continues in almost all offices.' Documentation was perceived as 'excessive' and administrative procedures as 'slow and cumbersome.' There was also concern that 'no one person' seemed to be in charge of the AVP leading some field staff to wonder 'where final approval authority rested.' Regional staff also complained about the absence of 'systematic quality control methods' in head office and the unreliability of the information system used to measure AVP workload. Staff also complained that there was 'not any consistent policy ... concerning the responsibility of, or contribution expected from family members in meeting the needs of veteran relatives ...with reference to the AVP.' Overall, regional offices saw the AVP as 'poorly understood by staff, poorly targeted, and vulnerable to change of focus on short notice.' The 'stated belief' of those working in the field was also that the 'AVP is targeted to the wrong veteran population.' The DPPE report also questioned the extent to which provinces were taking advantage of the AVP 'to transfer to the Federal Government

financial responsibility for provision of services which veterans would otherwise receive as provincial residents.’

These criticisms of the AVP did not detract from the authors’ overall conclusion that the program was a ‘conceptually appropriate and timely response to the needs of an aging veteran population’ which had succeeded in ‘reduc[ing] their risk of institutionalization’ and which employed an effective team-based multi-disciplinary approach to assessing need. But they nonetheless struck a nerve among some within Veterans Affairs headquarters who saw many of the report’s recommendations as ‘unclear,...vague and...rather poorly expressed.’ Of most concern was the argument that the existence of AVP had encouraged provinces to offload their home care responsibilities for veterans on to Ottawa. If true this could compromise the department’s plans to win agreement to a major expansion of the program. Further investigation revealed that, although some provinces such as Saskatchewan and Alberta, had indeed attempted to bill Ottawa for the cost of home care services supplied to veterans which were available to all provincial citizens, the problem had been resolved amicably through negotiations between Veterans Affairs regional offices and health officials in the respective provinces. Department officials also objected to the implication that groundskeeping services financed through AVP were being used as ‘backdoor’ for veterans seeking access to full treatment benefits. ‘The concept of AVP which was projected...was once into the AVP program a veteran could get any of the elements of AVP simply by asking for it.’ This was a ‘basic misconception’ conveyed by the DPPE report which showed ‘no appreciation of the need factor.’ Veterans qualified ‘for each separate area only on the basis of threat to independent community existence expressed by a need for assistance in activities of daily

living,' department officials argued. There was also grumbling about the DPPE's critique of geographic inequity within the AVP. Regional disparity was simply a fact of life, and certainly applied to the vastly uneven provision of provincial home care service. 'It will always be with us for as long as DVA continues to operate in an environment called Canada...Is it realistic to expect uniformity of services in such a land?' As for the DPPE's concern about the field staff's 'philosophy of client advocacy' this statement simply provoked bewilderment. "Is this good or bad? What precisely is meant by a 'philosophy of client advocacy'", Veterans Affairs officials asked? Although the evaluation report did not say, it was clearly not something for which the department's staff wished to apologize. Nonetheless, in his formal response to the DPPE report assistant deputy minister James Smith conceded that there was a 'lack of clarity for responsibility and authority for the AVP'; that the program's implementation had been 'less than adequately planned and controlled,' and that 'excessive paperwork or work-overload' was placing at risk the AVP's commitment to a multidisciplinary assessment process. All of these issues would be addressed in the department's plans to extend the program.

Throughout 1983 Robertson's AVP extension committee continued its work on detailed models of expanding the AVP to a wider constituency of veterans producing, with the aid of private consultants, different options ranging in cost from \$10.2 million to \$42.7 million a year. A key fiscal resource for making any of these proposals palatable, during a time of severe fiscal restraint, was the aging of the veteran population itself. Since half of all veterans would reach age 65 by 1985, increasing numbers were becoming eligible for Old Age Security and, if living below a minimum standard, the Guaranteed Income Supplement as well, programs which were both income-tested in much the same way as

the War Veteran Allowance and Civilian War Allowance. By harmonizing the administration of the WVA and CWA with the system already in place for delivering the OAS/GIS, run by the Department of National Health and Welfare, significant human resources would be freed up to help finance the extension of the AVP. As deputy minister Bruce Brittain put it, 'the AVP proposal hinges on shifting resources from the WVA/CWA Program'; therefore it was essential to present both initiatives to cabinet as part of a single package.

This is exactly what occurred when the AVP Extension proposal was forwarded to cabinet in late November 1983. Couching its recommendations as 'the last major program thrust within Veterans Affairs' and 'the final chapter in the body of legislation referred to as the Veterans Charter,' the department argued that its proposed broadening of the AVP represented 'the last major Departmental program changes required for these [725,000] Canadians' who with their spouses 'were now subject to the cares and stresses of age.' The AVP pilot project had proven to be a 'resounding success in fostering independence and preventing institutionalization.' Now that veterans in accelerating numbers were turning 65 and becoming eligible for OAS/GIS the cost of the War Veterans Allowance program was projected to shrink from \$437 million per year in 1983-84 to only \$110 million by 1991, 'a reduction of more than \$300 million...Less than one-third of this amount will accommodate health care needs of aging veterans ...at effectively 1/8 the annual per patient costs of institutionalization.' An extended AVP, in other words, was not only cheaper than institutionalization, but also could be easily financed within the department's existing budget since 'even when the cost of the AVP is taken into account, net projected expenditure for the Veterans Affairs Program will decline.' Harmonization

of WVA/CWA with OAS/GIS would produce the savings needed to underwrite the expansion of the AVP.

Extending the program to a wider spectrum of the veteran population would also pay dividends for Canadian society down the road. Because of their age profile veterans had twice the need for home or long-term care services compared to the general population. By the year 2000, when three million Canadians reached the age of 65, the rest of the country would catch up. At that point “Canada will be faced with the reality of the ‘grey wave’ resulting from the aging of ‘baby boom’ era children. Significant gaps in services, program know-how, and geriatric research must be filled. The Department is in a unique position to develop and prove creative responses for veterans that could have wide acceptance in the community in time to be of service to the future mass of elderly Canadians,” Veterans Affairs argued in its discussion paper to cabinet. Ensuring that veterans could spend their ‘remaining years...in dignity and, for as long as possible, independently in their own homes’ would also be popular not only with veterans themselves, but with their children ‘who traditionally are supportive of the Government for the care given to their parents.’ Failure to act, on the other hand, would result in ‘sharply increased demand for expensive institutional care.’ It would also be viewed by veterans and their families as evidence of a ‘lack of government commitment to fulfilling responsibilities identified in the Veterans Charter.’

The original AVP proposal, in 1980, had been justified on the grounds that it would save money on institutional care and department officials, in preparing their cabinet submission, were anxious to use evidence from a well-publicized 1982 Manitoba Home Care Study as definitive proof that the AVP would reduce Veterans Affairs need for

additional long-term care beds. Closer scrutiny of that study by the department's gerontologist, however, showed that "we are unable to draw conclusions from it which will permit us to say, 'By introducing an Aging Veterans Program expansion the Department of Veterans Affairs will save 'X' dollars.'" As a result, the language of the November 1983 cabinet submission was more cautious arguing that 'the potential impact of an extension of AVP eligibility on future bed requirements is difficult to predict with accuracy.' Given the limited experience with home care across North America it was difficult to make 'precise estimates of savings realizable from the proposed, more humane approach to care.'

Despite this caveat, Veterans Affairs attempted to shift the focus away from exact cost savings from the AVP, where hard data was lacking, to simply comparing the costs of home versus institutional bed care. From this perspective, the department's cabinet submission argued, there was an 'eight-fold difference' between the \$4400 average cost per person of its recommended AVP extension proposals and the \$36,000 annual operating cost of a domiciliary care bed. Put differently, by spending \$57 million, the department could either help 14,000 veterans to continue living 'in their own communities, most in their own homes' or assist 'only 1280 veterans...in new Type 1 and Type II institutional beds.' Framed in these terms the choice seemed clear. An extended AVP could serve 'a greater number of veterans...more effectively with funds that must otherwise be directed to expanding the number of institutional beds.' Canada's veteran population faced 'dramatic demographic changes in the next decade.' In response Veterans Affairs 'must act, and act based on its experience over the past three years if the overwhelming cost of inaction is to be contained.' Otherwise the department would

require 6250 contract beds by 1991, compared to only 4850 if the AVP was expanded along the lines being recommended. 'The cost of the traditional response to the plight of old people who can no longer survive at home on their own -that is, of warehousing them in institutions --will go right off the clock in a few years,' deputy minister Bruce Brittain argued in defense of the proposal. 'Costs, however, can be contained by the program...we have submitted today.'

Convinced by these arguments, and by the anticipated savings to be generated by WVA/OAS-GIS harmonization, the cabinet agreed in February 1984 to a phased in extension of the AVP over a four year period to 'all high risk veterans groups'. Beginning in October 1984 war disability pensioners 65 years of age and older in receipt of WVA, as well as non-pensioned WVA clients 75 years of age or older, would become eligible for the program. All remaining WVA vets 65-74 years of age would be brought in on 1 January 1986. In January 1987 war disability pensioners 65 years of age and older, unable to qualify for WVA because they were receiving Old Age Security, could begin applying for AVP. Finally, on 1 January 1988 non-pensioned veterans 65 years or older with theatre of war service, whose OAS benefits disqualified them from WVA, the so-called 'near-recipients,' would become eligible. The AVP was also expanded to include support for social transportation to assist in the activities of daily living. This phased-in expansion provided a 'learn as you go' approach that gave the department 'sufficient time to...complete the necessary program streamlining, training, management, and research information system and evaluation methodology to ensure that the expanded program will meet its intended objectives.' By 1988-89, when the extension of the AVP was complete, Veterans Affairs estimated that it would have a caseload of 11,105 veterans and would

cost (in constant dollars) an additional \$40.6 million a year. Significantly, although the department acknowledged the ‘vital role of spouses in maintaining the well-being of entitled veterans’, it did not propose to include them within the circle of eligibility for any components of an extended AVP, beyond the limited provision, in place since 1982, that veterans widows could continue to collect contributions to a maximum of thirty days following the death of their spouse. “Members of the veteran’s family and...his wife...are expected...to take a ‘team’ approach to family responsibilities including those with which the veteran is unable to cope...A ‘family member’ is a ‘family member’. Society expects families to have ties and responsibilities and to accept these,” Veterans Affairs minister Bennett Campbell argued in making the case against extending AVP benefits to caregivers

Nonetheless, from the beginning a number of officials within the department, such as Stu Tubbs, one of the original designers of the AVP, were ‘very supportive, very early on of trying to include spouses in terms of benefits or of not stopping benefits at the time of death because of the problems that would create.’ As early as 1982, Veterans Affairs staff planning for the AVP extension ‘talked about waving a red flag to Cabinet that would indicate the Department’s future desire and intention to address the needs of veterans’ spouses or widows in the future.’ Once the AVP was opened up to a much wider constituency of veterans in 1984, some of whom then began to die, complaints from field staff began flowing into department headquarters about the failure to acknowledge the needs of their wives. ‘It didn’t certainly take place all at once. It was sort of gradual and incremental,’ Darragh Mogan recalled. ‘Anecdotal evidence was probably as much of an influence at the time as anything else. Because increasingly...counselors would be going into individuals homes and seeing actually what was happening. And in actual fact you

couldn't very well help the veteran without helping his spouse, there was no way you could do it and so again it was an absurd position of helping the one individual because the other individual was key to the person staying at home.' As a result, by 1984-85 counselors were instructed 'to consider the whole family circumstances in running a care plan.'

As Duncan Conrad from department headquarters noted, 'whenever a counselor went into a veteran's home the interview was always with the veteran and the spouse, generally a woman in most cases who was the caregiver...Even in the early stages...there was always a recognition that beside every good veteran was a good spouse that was providing some sort of support...We ended up really recognizing that the contribution that caregivers made needed to be captured. So our...process was changed...to actually add an assessment component that took in the role that the caregiver was playing...It gave us a picture of what the health of the caregiver in the home was, and also what the contribution was they were providing.' Once counselors were asked to document the key role of spousal caregivers while the veteran was alive, it was but a short step to underscoring the difficulties they faced once their partner had died and they suddenly found themselves cut off from all further AVP support. "They were getting letters saying, 'how can I continue?' ...Without the spouse these guys would never have lasted as long as they did. They were by their side when they were at war, and by their side all their lives, taking care of them in the illnesses and their disabilities. How could you go and turn your back on these women?," department officials recalled.

As a result, shortly after the AVP was extended district counselors began writing to department headquarters asking 'why does attendance allowance continue for widows

for one year after a Veteran's death yet AVP stops?...Widows should receive AVP benefits at least to the end of the contribution period at a minimum, and preferably should receive ongoing assistance.' Officials in Charlottetown headquarters acknowledged it was a 'difficult question', particularly since within other Veterans Affairs programs such as War Veterans Allowance, the widowed spouse 'continues to receive WVA at the married rate for an adjustment period of one year. Similar arrangements are in place for [attendance allowance]...and the disability pension itself...We have a long tradition of providing income support to the surviving spouse until his/her death.' Since the spouse was not a veteran there was 'no basis in law to do anything [but] there is clearly a moral obligation.' Others disagreed that the department was not legally obliged to act since its statutory authority obligated Veterans Affairs to be responsible for the care, treatment, training, and re-establishment of veterans 'and the care of their dependents. Spouses are dependents and their welfare is our concern and responsibility. How can it be humanely rationalized that while the veteran lives we assist him in the care of his spouse, but after he dies we abandon her? The need for spousal assistance is much greater, generally, after the veteran dies than while he lived.' Why shouldn't counselors undertake 'an assessment of the surviving spouse's need and maintain, reduce, or increase the care plan which is suitable or required for the remaining spouse?'

In response to this pressure, mostly coming at this point from Darragh Mogan's own staff, a draft regulation was circulated in the summer of 1985, proposing that district offices be allowed the discretion to continue AVP benefits for home care, home adaptation, and transportation service, which were in effect at the time of a veteran's death, to his or her spouse for a period of ninety days, but 'only in those cases where the

AVP services would assist the spouse to cope with the activities of daily living.’ District staff were warned that ‘care should be taken not to create a state of dependency.’

Extending AVP to widows was to occur only ‘where her needs were identified as being part of the package when the veteran was alive; [on the understanding] that she would not be offered institutional admission nor greater financial support than was in pay at the time of the veteran’s death, nor any residual treatment benefit entitlement.’ However, the proposed regulation change was not approved on the grounds that the department had taken the ‘strong position that the Provincial government has a responsibility for the health care of spouse’ and did not wish to break this precedent.

NOTES

Chapter 4

FROM THE AVP TO THE VIP: THE GEORGE HEES ERA

In September 1984 a new Progressive Conservative government led by Brian Mulroney assumed office. During the 1984 election, capitalizing on unhappiness among veterans organizations around the relocation of Veterans Affairs headquarters from Ottawa to Charlottetown between 1979-84, the Tories targeted veterans as an important constituency in their campaign, promising to sharply reduce the processing time and significantly expand the range of veterans benefits. To make good on this pledge, Mulroney appointed a high profile cabinet minister from the Diefenbaker era, George Hees, as his Minister of Veterans Affairs. The popular 74 year-old Hees, a member of Parliament since 1950, was a decorated World War II veteran who had been wounded during his service abroad. Along with Daniel Macdonald, the double amputee veteran who served as Pierre Trudeau's longstanding minister of Veterans Affairs, Hees would become one of Canada's most successful advocates for veterans needs. 'All Canadians are special but veterans are very special,' Hees proclaimed upon taking up his new cabinet position. 'They went overseas and took a chance on getting their heads blown off so their country could remain free. For that reason I want all veterans and their submissions treated with the very greatest of generosity, courtesy, and efficiency...I want the benefit of the doubt to be given to the veteran.' As officials within the department recall, "because he was a veteran...he was the greatest ally and supporter the veterans ever had...next to Danny MacDonald who was also a double amp himself. George Hees was a real promoter...There was just a major difference in approach....The bottom line was 'be

generous'. And people were very generous. That permeated the organization very rapidly."

Hees' first initiative was to insist that the name of the Aging Veterans Program be changed. 'Everybody is starting to age once they get past 40, but nobody likes being reminded about it. Many of us won't even admit it. Had I been around at the time, I would have named the Program M-V-P instead of A-V-P. Then it would have been the Mature Veterans Program, or even better, Most Valuable Players,' Hees quipped in a speech before a group of veterans shortly after becoming the department's new minister. Over the next year he continued to press Veterans Affairs staff to come up with a new title for the AVP, a task which met with some resistance from senior officials who balked at the unnecessary cost of such a change and the possible confusion it might create among the program's aging clients. The 'Victory Program', the 'V' Plan, the 'Live' Program, the 'Independent Living Program', the 'Veterans Care Program' and the 'Community Care Program' were all titles considered and rejected. Finally, Ontario region director Don Ferguson initiated a contest among his staff to come up with a new title. Out of 163 entries received the most popular was 'Veterans Independence Program' (VIP), a name Ferguson initially rejected because it duplicated the acronym of a popular Ontario government initiative. Nonetheless, Hees liked VIP because the initials captured perfectly the message he had been publicizing since taking over the department. 'The new name reflects the Government's philosophy that veterans are very special Canadians, and VIP acknowledges the program's substantial achievements to date.' And so, in January 1986 the AVP became the VIP.

As Hees frequently commented, the VIP was 'a very great favourite of mine' and

his arrival as Veterans Affairs minister coincided with its phased in expansion between 1984 and 1988 to new categories of low-income veterans, a move which, as previously discussed, had been approved by the preceding Liberal government. As part of their election campaign the Conservatives promised to 'make things hum' on veterans' benefit applications, a pledge Hees subsequently transformed into vowing his department would cut the time for processing veterans' benefits in half. Since Veterans Affairs was given no additional person years from Treasury Board to administer the VIP and officials confessed that 'no one had any idea that the [program] would continue to grow at the rapid rate it has' the challenges faced by the department in administering it during the second half of the 1980s were formidable.

The department's response was to search for ways of 'streamlining' the program. Even before the change in government, officials realized the VIP was 'labour intensive and time consuming', overly centralized and badly in need of being made 'administratively clean and efficient.' Because it was a 'contribution' program in which veterans were compensated for home care expenses after they had been incurred, the VIP required the keeping of 'voluminous detailed records... by both the District Office and Regional Finance,' for quite small and routine expenditures. As district officials complained, 'each veteran's... contribution is separately calculated and recorded, and duplicate sets of invoices, receipts, contribution payment documents, and running balances are kept by both Finance and the District Office.' Over 90 per cent of these agreements were 'straightforward repeats of the previous year's requirements,' but each one had to be separately 'renewed, signed and placed into pay' through a system some officials characterized as 'handraulic'. As a result, by 1986 there were 'currently 1200 renewals a

month...taking up to four and five months to process in some cases,' leaving many low-income veterans 'seriously out-of-pocket' waiting for reimbursement of personal payments to suppliers.' The VIP's excessive paper trail 'frustrate[d] health care planning' and also served to 'confuse older veterans because of the detailed accounting required by each client,' officials pointed out. Others characterized the program 'a nightmare to administer.' It was clearly not a system that could easily cope with the thousands of new cases coming the department's way once eligibility for the VIP was extended to low-income veterans after October 1984 and the program caseload tripled over the next three years.

Indeed, by 1986 after all WVA clients age 65 and over became eligible for benefits, department officials calculated that the administrative costs of delivering the program were running at 18 per cent of total benefits being paid out, a figure that was 'unacceptably high' and more than double the rate of standard administrative costs for health service programs in the private sector. At a minimum department officials wanted to see administrative costs of VIP reduced to eight per cent of benefits. As one internal department study concluded, the VIP's delivery policy was 'imprecise...and unclear in relation to other Veterans Affairs' services'; the 'centralization of decision-making... was inefficient,' and the department possessed 'no approach to caseload management' or strategies for realizing 'economies of scale.' With potentially 30,000 new clients coming on stream after 1 January 1988 and no prospect of additional administrative resources to handle their needs, a crisis was looming unless significant changes for simplifying the delivery of the VIP were put into place.

Three key recommendations emerged out of internal department studies for

‘streamlining’ the program between 1986-87. The first was to delegate more decision-making authority downwards onto district and area counselors, a development which reflected a significant transformation of personnel within the department. As a former district counselor recalled: ‘Within our organizational culture [during the 1970s and early 1980s] there was more of a military influence amongst the staff...There was the remnants of the actual veterans working in here. And it was a highly structured, fairly hierarchical almost, I hesitate to use the word authoritarian, but there was elements of it there. A little paternalistic. No doubt about it. And we didn’t involve the veterans as much in the decision-making as we do now. And we certainly didn’t involve, as we do now, their sons and daughters.’ By 1987, however, as a result of significant changes in hiring and job training practices within Veterans Affairs, 52 per cent of the counseling staff had university degrees. An additional 25 per cent were enrolled within or had completed community college certificate or in-house training courses in gerontology. As a result, senior management was ‘now confident that the skill and experience of the counseling cadre is at a level where their role in the delivery of the program could be increased to include decision-making for benefits in cases where the risks are determined to be low.’

Beginning in September 1987 a new ‘three-tier approach’ for screening VIP applications as low, medium or high risk received Treasury Board approval. District counselors were granted authority to approve ‘low-risk’ non-medical benefits such as housekeeping, groundskeeping, and social transportation, which made up 87 per cent of all VIP agreements among the program’s 17,000 clients, on their own initiative and without the need for assessments by the District Office nurse. The remaining 13 per cent of medium or high risks cases requiring direct patient care, personal care, or ambulatory

health care would continue to require the approval of area assessment teams or Veterans Affairs headquarters in Charlottetown. Secondly, agreements could now be signed on a three or five year basis, rather than having to be renewed annually. Finally, quarterly or monthly advance payments to veterans would be allowed in cases where it was 'determined that prepayment by the VIP recipient would result in financial hardships.'

Some regional officials within the department worried whether district counselors were 'adequately trained to make decisions based on their assessments' while medical personnel objected to the fact that 'the nurse was being removed from the process.' Senior officials in Charlottetown were less concerned since the overwhelming majority of VIP clients were the 'young-old' in the 64-74 age range with relatively low level needs for housekeeping and groundskeeping. Delegating more authority for decision-making around these services 'had been very well received by counselors and field operations staff ... [and] has evoked a new sense of professionalism.' The real need for training lay in the area of 'case management.' Unless this concept was 'driven home,' to district counselors there was a danger that 'all contributions will be approved for efficiency sake for the maximum period with inadequate individual case planning.' Armed with more authority to make decisions on their own, counselors, the department hoped, would begin to accept 'the concept of caseloads, as opposed to workloads.' Nonetheless, over the next few years reports of counselors in some regions being asked to meet 'case load quotas' continued to filter back to Veterans Affairs headquarters, much to the consternation of senior department officials, and a subsequent department internal study concluded that the initial case management process for the program was implemented with 'considerable difficulty' and was 'not well-designed.' Over the next decade as the VIP clientele moved into deeper

old age and began to present more complex health needs, the skills required for successful case management would become a more urgent theme in policy deliberations surrounding the program.

As noted previously, when the AVP's extension was initially approved in November 1983 the program's caseload was expected to reach 11,105 by 1988-89. Instead, the VIP had 16,247 clients in fiscal year 1986-87, 23,900 in 1987-88 and 40,369 by 1988-89. With its caseload growing at the unexpected rate of 70 per cent a year during this period as a result of widening eligibility and greater than anticipated popularity, the VIP not surprisingly experienced significant growing pains. The number of disability pensioners accessing VIP, for example, was 'more than double the number' the department anticipated when the program was introduced, in part as a result of the War Amps and the Legion's aggressive promotion of the program to their pensioned members. It was 'a large volume of work to absorb in a downsizing environment', officials complained, a problem compounded by confusion as to whether any additional staffing resources would be made available to support the ballooning caseload. As noted previously, the VIP had been extended 'on the understanding that funding and resourcing would come from lapsing WVA/CWA dollars and the savings attributed to Harmonization/Service policies,' as aging WVA/CWA recipients turned 65 and began to access OAS/GIS. However, 'neither the VIP nor Harmonization/Service policies have been accurately costed,' assistant deputy minister Donald Ferguson pointed out in the spring of 1986. As a result, the department had 'no accurate idea if the...extended VIP can be funded and resourced within existing and planned [staffing] levels.' With its administrative costs running at over 18 per cent of benefit payments, however, the

department was not in a strong position, in a climate of government fiscal restraint, to go back to Treasury Board requesting more staff. It was 'the administration of the Veterans Independence Program [which] need[s] fixing most', Ferguson argued, and the goal was to get costs down to 'as close to 8% of the benefit payout as possible.'

This point was reinforced by an internal quality control study, sampling over 321 VIP case files across the country, which revealed significant regional differences in how the VIP was being delivered. In the Atlantic region only 20 per cent of applications were forwarded beyond the two person Assessment Review Team to the more expensive and time-consuming multidisciplinary Health Care Team. In the Pacific Region the comparable figure was 75 per cent. Average turnaround times for processing applications ranged from 73 days in Atlantic Canada to 51 days on the Prairies. 'In all cases time from application to contribution arrangement seems very long', senior department officials concluded. For a national program, it was essential that 'national standards should be established for turnaround times for all levels of decision-making.' The Ontario, Pacific, and Prairie had each developed and were using their own application forms rather than a standard national form. Sixty per cent of all VIP cases did not use any community resources, an 'astounding percentage' the study's authors commented, since 'there must be a goodly number of clients who...are not eligible for VIP but would qualify for some community resource or agency.' It was 'essential to have a process in place which effectively and efficiently screens, assesses and makes decisions in those cases where VIP benefits are requested.'

A second in house evaluation, the Veterans Independence Program Project, established in October 1987 to 'streamline the efficiency of the program and to conduct a long-term policy and operational review' also trained a spotlight on administrative gaps

within the program. Because of personnel shortages as well as 'staff without skills or training' in case management, the screening process within the VIP had been 'applied inconsistently' and revealed an 'inappropriate use of scarce resources.' Since the department had also failed to implement a 'national training program' skills levels of counseling staff 'varie[d] considerably from region to region and district to district.' Ontario and Quebec regions had provided 'considerable training in the area of home care programming' but there was 'relatively little training...provided to staff in the Atlantic, Prairie and Pacific Regions.' The VIP also needed to develop an adequate, consistent, and automated national data set to allow for intelligent planning and management of caseloads since 'a number of [its] forecasting assumptions have never been validated.'

The explosion of caseload growth beyond all expectations, over the previous four years, was one illustration of this point. A second was the fact that despite frequent claims by Veterans Affairs that homecare provided through the VIP was eight to ten times more cost effective than supplying institutional beds, the department had no solid research to back this up. 'We have not thus far carried out a case evaluation sampling to assess the effectiveness of interventions in maintaining or improving client self-sufficiency,' officials pointed out. 'Is the health economics premise of demand rising to meet supply the case or are we responding in an effective manner to a gap?' Put differently, was homecare through the VIP an add-on or substitute cost for long-term care beds in the community? '[I]t is difficult to speculate as to whether \$10 to \$20 million annual expenditure on home care is increasing self-sufficiency or maintaining veterans in their own home or community,' a 1987 in-house evaluation of program concluded. 'The [VIP's] effects on clients have not been determined.'

In order to address these questions, in late 1987 the Program Evaluation Directorate of the department, as phase two of its review of VIP, sent out a request for proposals to external consultants for an independent in-depth study of the program. The purpose was to address eight key questions. Was the VIP meeting its objectives? What was its effect on the health of clients, their caregivers, and their families? Were veterans satisfied with it? To what extent had the VIP reduced demand for long-term care institutional beds? Was it cost-effective in comparison to other alternatives? Was it duplicating provincial or local home care services? What, if any, were its additional benefits and costs? What additional services or benefits were required to enhance its effectiveness? The contract was awarded to the major consulting firm Price Waterhouse, in February 1988 with a scheduled completion date of November 30 that same year. Apart from the internal benefits of such a review, Veterans Affairs officials also saw it as an important opportunity to publicize the innovation and importance of the VIP. 'The professionals all say that VAC is out front and we at VAC have to help in preparing for the gray wave,' assistant deputy minister Don Ferguson argued as the study began. 'We have made statements as to the validity of [the] VIP and now is the time to tell what is going on and what has happened.'

Before beginning the study the Price Waterhouse consultants highlighted a number of important methodological obstacles which stood in the way of determining whether or not the VIP was cost-effective. First, since the evaluation team would be looking at existing VIP clients there was no 'control group' with whom they could be compared nor any 'baseline condition' against which their current situation could be contrasted. As a result there was no way of proving what would have occurred to them in the absence of the VIP.

‘[N]o fully adequate’ way existed of getting around this conceptual problem. Second, given the wide discrepancy among provincial home care programs which the VIP ‘topped up’, its delivery differed markedly ‘from province to province.’ Moreover, precisely because it was a ‘top-up’ to provincial home care services, it was difficult to separate out the VIP’s effects on clients’ health and self-sufficiency from those same provincial or local services. Third, although assessing the ‘cost-effectiveness’ of the VIP was important, this was not the only stated rationale for the program. It was also intended to improve the health and self-sufficiency of veterans, objectives which could be met whether or not they were ever in danger of being institutionalized. ‘No expected cost savings in relation to institutionalization would be expected in these circumstances.’ Fourth, since clients to be contacted were already getting a service from Veterans Affairs, they might be ‘reluctant to report any dissatisfaction with the program for fear it might result in [its] reduction or elimination.’ Finally, it would be difficult to prove the VIP prevented or delayed institutionalization if there were insufficient long-term care beds within the community for clients to have the option of choosing them.

The research design of the project relied on three strategies. The first was a sample review of 300 case files, chosen from among the 23,000 VIP clients across the country, to be conducted in consultation with Veterans Affairs counselors and district nurses familiar with each case, followed up by telephone interviews with the VIP clients, their family members and informal caregivers. The second was the mailing out of a survey questionnaire to a random sample of 1000 veterans different from those to be interviewed by phone, from which 727 replies were received. Independent nurses were hired on contract by Price Waterhouse to conduct the file reviews and telephone interviews. When

these were completed each nurse was asked to rate the veteran's likelihood of institutionalization, 'both with and without VIP service'. If the client was rated a medium or highly likely candidate for institutionalization, the nurses were asked to provide 'both a provincial and generic estimate of the level of care and type of placement' the client required. Costs for institutional care would be based on 'estimates...for facilities actually accessible to the veteran in the closest district in which they resided.' The study simply 'assumed' such bed care was available. These costs would then be compared with the actual expenditure of home care services on the client through the VIP, other department programs providing medical or home assistance, expenditures made by the veteran himself and those made 'free of charge to the veteran on the part of the province or municipality.' The third technique was to interview 27 veterans already institutionalized within facilities in six cities across Canada to determine whether the availability of the VIP would have provided a viable home care alternative. Focus group discussions with Veterans Affairs counselors and telephone interviews with provincial home care officials also rounded out the consultant's research. After 11 months of work a first draft of the Price Waterhouse report was completed in January 1989 followed by a final draft in June which incorporated feedback from senior VIP administrators.

The typical VIP client, the study revealed, was a married male between 65-75 years old living with his spouse and family or friends. Most had lived in a city or town for more than ten years and owned their own home with family within one hour's driving distance. Three-quarters were pensioners. One-half of clients in the study had been admitted to hospital at some point over the past three years. Seventy-five per cent rated their own health as 'fair' or 'poor' and eighty per cent were suffering from at least one

chronic condition. Two-thirds could be left unattended in their own homes; seven per cent could not be left by themselves and 21 per cent could only be left alone for up to three hours. Only 35 per cent of their caregivers were rated by Veterans Affairs counselors as being in excellent or good health and one quarter were in poor health. This was a key finding, the report noted, since 'caregiver health status has implications for the amount and type of services needed by veterans to enable them to remain in their own homes/communities,' a theme that would grow in significance over the course of the next decade. Most clients were receiving housekeeping or groundskeeping services through the VIP which were supplied by independent providers, friends or family members, the last method being by far the one most preferred.

Unquestionably the most important finding of the Price Waterhouse study was the high level of client satisfaction with the program. Over 90 per cent of both veterans and their informal caregivers reported that they were 'moderately' or 'extremely satisfied' with the services they were receiving. The only significant concerns noted were difficulties in locating service providers and delays in being reimbursed. Thirty per cent of those surveyed, however, reported a significant unmet need, most often heavy housekeeping services, which was impacting on their ability to remain at home. Overall the study concluded that 'client satisfaction with the VIP was extremely high in all evaluation areas: quality, amount, timing and adequacy.' Three quarters of the veterans and over half of their counselors, informal caregivers, and nurses reported that the program had made a moderate or great deal of difference in the client's health. Three-quarters of the clients also said the VIP had made a difference in their life satisfaction, mostly because of reduced worry about finances and the feeling that 'someone else cares about how you are doing.'

Reducing worry, in fact, was the most common factor cited by clients for why the program had improved their health.

The reasons why were evident from further survey results. The ‘vast majority’ of clients reported difficulties in managing at home prior to receiving the VIP. Without the program almost half said they would have difficulty doing yard work or snow shoveling, 36 per cent said general house maintenance would be a problem, 20 per cent singled out difficulty climbing stairs or getting in and out of the bathtub. One-quarter were extremely limited in their ability to perform the activities of daily living. Eighty-six per cent reported that the VIP had made a moderate or large difference in their ability to manage in their own home. In short, in terms of meeting one of its principal objectives, improving the self-sufficiency of veterans in the activities of daily living, the VIP was clearly a great success.

It also made a significant difference for their spouses. Sixty per cent of counselors, 53 per cent of nurses, 69 per cent of veteran clients and 88 per cent of their informal caregivers reported that the VIP had made a ‘moderate’ or ‘great deal’ of difference in reducing the burden on caregivers and 56 per cent of family caregivers reported that it had improved their own health. ‘The impact of providing overall relief for family is strong,’ the report argued. It was a finding of some importance. As the authors argued:

when the health of the caregiver is good, it can be expected that they will take on a variety of care activities on behalf of the veteran. If the health of the caregiver is poor, many of the care activities...will likely be transferred to the formal service system. Consequently, improving or maintaining the health status of the caregiver potentially expands or sustains [their] capacity to continue to care for their loved

one. This, in turn, can decrease the amount of formal service assistance required by the veteran.

Put differently, keeping the caregiver healthy reduced the long-term costs of veterans benefits to the state. Nor was the VIP displacing informal care. 'In general the pattern of help and visiting was reported to be undisturbed by VIP.'

But did the VIP significantly reduce the demand for institutional beds? This, after all, was the second and perhaps more compelling argument for the program, at least in the eyes of the central agencies in Ottawa. On this point, the findings of the Price Waterhouse report were less conclusive. 'The vast majority of home care recipients were not at high risk of institutionalization,' its authors noted. At best only one-third of the cases reviewed by the nurses hired for the study were deemed to be medium, high, or very high risk of requiring institutional bed care, in the absence of the VIP. Since the most common services provided through the program were groundskeeping and housekeeping rather than personal or direct patient care, this finding should not have been all that surprising. Nonetheless, it did create some problems for underscoring the VIP's cost-effectiveness. No part of the Price Waterhouse report was more troublesome than its attempt to estimate how much money the VIP actually saved. If all clients served by the program were cared for in institutions, the report argued, the cost would be an additional \$193 million. But this clearly was an unrealistic comparison since the overwhelming majority of the program's caseload did not need institutional care, and even if they had, a sufficient supply of beds was simply not available for them. Depending on the assumptions used, the report argued, estimates of cost-savings from the VIP could 'vary from \$6 million to \$214 million when

VIP costs alone are compared and from \$21 million to \$181 million when total DVA costs are compared with the costs of institutional care.’ Such a huge range was not terribly helpful in making a convincing case for the cost effectiveness of the VIP. The report’s best estimate was derived from the national sample of almost 300 VIP case files reviewed in depth by their contract home care nurses. Using a probability scale for estimating what proportion of these clients would require institutional care in the absence of the VIP and extrapolating this number as a percentage of the total of VIP caseload across Canada, the study argued that the VIP likely saved Veterans Affairs \$33,000,000 annually, assuming that the cost of a long-term care bed was approximately \$31,000 per year and that only 25 percent of veterans requiring such a bed would actually find one in their community if no VIP was available. It was an estimate which ‘should be treated with caution,’ the authors conceded.

Senior department officials were pleased that the Price Waterhouse study was ‘thoroughly done’ and ‘gave the [VIP] a good bill of health.’ They were particularly delighted by the high level of client satisfaction it revealed and by its recognition of the importance ‘of informal caregivers to the current and future needs of the veteran for institutional care and other formal (and expensive) services.’ ‘[M]ost of the recommendations are to hold the course’ and ‘you’re right on target,’ senior staff observed. Proposals for expansion into new areas were downplayed. Since the VIP was ‘growing this year at a 70% rate and will triple again over the next 3 years, we must first ensure we can continue to deliver the existing program.’ There already was an ‘insufficient number of staff....to deal with an estimated VIP caseload of over 100,000 by 1991-92, increasing to over 120,000 by 1994-95.’

The study's cost-savings estimates, however, were deemed 'so soft that [they are] an easy target for criticism.' Since the range stretched 'from the hundreds of millions to about 6 million my view is that these figures should be far in the background,' Darragh Mogan argued. Other senior staff pointed out that 'this is an area that the Department must have a handle on to support the VIP to senior levels of government.' For the time being the consensus in Charlottetown was that the department should simply underscore the study's conclusion that 'the VIP is cost effective when compared with the alternative' and focus instead on quality of life arguments, by noting that the program 'has had a great impact on allowing clients to remain in their own homes or community...It should be dealt with in a way that expresses the psychological, emotional, and social importance of seniors remaining in their homes or community.'

While the Price Waterhouse study was still underway, the VIP stood on the threshold of yet another major expansion. During the 1984 election campaign as part of their strategy of targeting veterans, the Conservatives promised, if elected, to extend eligibility for the War Veterans Allowance to those who had volunteered for active duty, during the Second World War, and were assigned to serve in Canada for a period of at least 365 days, a group known as 'Canada Service Only' or (CSO) veterans. The demand for their inclusion within the terms of WVA had been part of the Legion's regular annual lobbying since 1974, but it accelerated dramatically after a series of rulings by the War Veterans Allowance Board, beginning in 1981, determined that 'theatre of war' service could include moving back and forth across the Northumberland Strait or the Bay of Fundy. In the eyes of many veterans, decisions such as these made previous eligibility distinctions between overseas and Canada service veterans for important benefits such as

WVA and VIP appear increasingly anomalous.

Three years into its mandate, however, the Mulroney government had still not acted on its campaign pledge to extend eligibility for the WVA to CSO veterans, citing the higher and more costly priority of ensuring a sufficient supply of long-term care beds for aging veterans. The Legion countered by arguing that the needs of aging CSO veterans were immediate and should not be traded off against possible shortages in long-term care beds down the road. By 1987, with another election near, the quest for redeeming the promise of WVA eligibility for CSO vets had become 'the Legion's top priority.'

'Pressure from veterans organizations has been constant,' department staff acknowledged, as a result of a 'very real and concerted campaign' led by the Legion, and supported as well by the National Council of Veterans Associations in Canada and the Army, Navy & Air Force Veterans of Canada. As a compromise gesture, the Legion reduced its original demand by arguing that WVA eligibility should apply only to CSO veterans age 65 rather than 60, the normal threshold for applying for the WVA. Since veterans reaching 65 were already eligible for OAS-GIS, this was a much less costly proposal.

Once they were eligible for WVA, CSO veterans could also apply for the VIP and full health and treatment benefits. This was the key incentive behind the Legion's campaign. As Veterans Affairs staff pointed out:

ninety percent of the income support needs offered...by WVA can be met by OAS, GIS and SPA [Spouses Allowance]. In five years virtually all veterans, CSO and Overseas, will be eligible for OAS, GIS or SPA. It is clear that the issue for Veterans' Organizations is not so much the small WVA 'top-up'...but the gateway

such eligibility provides to health care benefits where the level of financial support can be very significant. Such a gateway for the Veterans Independence Program alone doubles the program costs...In addition, Veterans' Organizations may expect CSO 'near recipients' to be 'gatewayed' as well on the same basis....This has the effect of increasing the Veterans Affairs health care caseload and benefit and operating costs four times.

From both a policy and program viewpoint department officials were reluctant to accede to this request. From a policy standpoint CSO eligibility would "wipe out the 'theatre of war' requirement from the law so that those who were not even at risk from enemy action [could] also qualify" when there was no evidence their economic need was related to their war service in Canada. This would represent a 'major shift in government policy.' The CSO category of veterans in 1988 stood at 327,000 which was slightly larger than the 317,000 veterans who had 'theatre of war' service overseas. Providing them with WVA eligibility and a 'gateway' into VIP and full health treatment benefits represented a potential doubling of the costs and demands on these programs.

It was also a clientele with whom the department had had little contact. 'Canada Service Veterans, their locale, health status, local support network, and the like are completely unknown to DVA,' officials pointed out. 'For many, this could be their first encounter with Veterans Affairs...[T]he implicit per case labour costs could be significant. Moreover, our estimates of their numbers and distribution and probable interest in the VIP program are all inferential...with all that entails about the reliability of caseload projections.' CSO eligibility would also 'inevitably lead to pressure from other groups

(e.g. Red Cross workers and firefighters in Canada, merchant seamen, veterans who never returned to Canada after the war).’ In terms of program priorities, Veterans Affairs headquarters also remained convinced, from their own long-term forecasts, that the costs of providing chronic care beds ‘needed in increasing numbers up to the early part of the next century...should have higher and more immediate priority over extending eligibility to the CSO group.’ However, the realities of an upcoming election over-rode these concerns. As George Hees pointed out to his cabinet colleagues, ‘from a political viewpoint...it is clear we made a commitment before the last election that we haven’t kept. The opposition parties have supported the Legion’s demand. About 1 million voters have a direct interest in this matter. Pressure can be expected to increase reaching a crescendo in June when the Legion holds its national convention in Ottawa.’

It was an effective argument. Hees convinced his colleagues to accede to the Legion’s request, with two significant revisions. The Legion had wanted only CSO volunteers, not conscripts, to be eligible to apply for the new benefits. Since this distinction would only reopen old wounds it was politically unacceptable to cabinet. The new criteria would apply to all CSO veterans who served at least 365 days in Canada regardless of whether they volunteered or were conscripted. They would also be granted eligibility only to apply for the the VIP, not WVA. This represented ‘a comparatively low cost creative response to the priority demand of Veterans’ Organizations’ which also addressed their ‘area of greatest concern (availability of long-term care support in the home or community).’ At the same time it also avoided the more major policy shift of abolishing the ‘theatre of war distinction’ for benefit eligibility, a move which threatened to leave Veterans Affairs with ‘no viable policy position remaining to resist pressure’ for

further extensions of eligibility to other civilian groups and their dependents. 'Government has received much support for the Veterans Independence Program. Offering its benefits could be more popular and more effective than the straight [WVA] cash transfer.'

On 13 June 1988, three days before his 78th birthday, George Hees appeared at the Canadian Legion's annual convention in Ottawa to tell the assembled delegates the good news that their 'concerted campaign' had paid off. 'I am delighted to announce today that the government has approved that those who served in the Canadian armed forces for at least a year during wartime in Canada and who are at least age 65 will be eligible for the Veterans Independence Program if they are in economic need....And that's not all. Those veterans who qualify and need VIP to help them remain independent in their homes will automatically qualify for treatment benefits once they are in receipt of VIP.' The response to Hees' announcement, the Legion magazine reported, "was loud, clear and predictable: a standing ovation from more than 4000 delegates and observers....'I can't find the words to thank you enough,'" the Dominion Command president, Anthony Stacey told Hees as the applause subsided. 'I just don't know what to say.' Bringing CSO veterans into the VIP would cost \$200 million over the next five years, Hees told the delegates. It would also 'more than double the number of veterans potentially eligible' for the program and most likely increase its caseload 'from some 30,000 to well over 40,000. And these numbers we know will continue to grow.' Nonetheless, the outgoing Veterans Affairs minister also vowed that these additional costs would not come at the expense of Ottawa's commitment to find additional chronic care beds, of good quality, for those who needed them, a demand which would 'also increase sharply.' 'These beds pick up where VIP leaves off. VIP is designed to help veterans live in their own homes. When that's no longer

possible VIP can cover residential, domiciliary, or nursing home care...I'm confident that with the cooperation we expect from the provinces, everything will be done to ensure beds are available when they are needed...Indeed, it is my pledge to the veteran that those beds damn well will be available.'

Hees' boast belied deeper concerns within his department that, despite the VIP, the department faced a looming crisis in meeting the anticipated demand for long-term care beds for aging veterans. Male veterans of the First and Second World Wars and the Korean War were not an insubstantial segment of the population. At an average age of 68 in 1988 they comprised 'approximately one third of the total Canadian male population over age 65 and 50% of all disabled elderly males.' Over the next decade their needs for care would be accelerating rapidly. Since 1984 Veterans Affairs had imposed a freeze on the total number of departmental and contract beds, on the assumption that the VIP would cut the demand for long-term care by approximately 1200 beds. Eleven hundred beds remained in the department's remaining four long-term care facilities. Another 3000 additional 'contract' beds were reserved for veterans in 26 provincial or non-profit community facilities, paid for by Veterans Affairs. Taken together the cost of maintaining these 4000 beds consumed almost half of the department's total health care budget.

By 1988 a major review of the department's projected long-term care needs between 1990 and 2020 argued that this total was not nearly enough. Two of the existing veterans' institutions needed to be replaced and a third required major renovations as did three of the contract facilities. During the previous five years the number of veterans requiring chronic Type 3 care had doubled.

The current unsatisfied need for beds is believed to be about 1400...Without the Veterans Independence Program...this demand...would be even higher....

However, the number of VIP clients is expected to double within the next five years and community long-term care facilities may become increasingly inaccessible to veterans because of growing lists of community residents awaiting admission. In addition, provinces are tending to devote most new health care funds for the elderly on home care and home support resulting in little expansion of long-term care facilities.

Despite taking a 'conservative' approach, the authors of the forecast argued that their results were 'startling, if not alarming.' By 1991 more than 7000 veterans would need long-term care beds. Ten years later, when the demand peaked, the department would need to provide 11,000 beds, to about 7 per cent of the total eligible veteran population. Almost 4700 would require the most expensive type 3 chronic care beds compared to the 2300 Type 3 beds presently available. And bringing such beds on stream required a lead time of five years. Depending on which policy route Veterans Affairs took, costs could range from \$520 million in capital and \$220 million in annual operating costs if the department built and ran the facilities themselves to approximately \$200 million in capital and \$45 million in operating costs if they worked through the provinces. Whatever course was followed, the need for more long-term care beds was 'immediate' and would continue until it reached a peak eighteen years later. Not to respond would be viewed as a "breaking of faith' on the part of the government and a denial of earlier promises and assurances that veterans would be fully compensated for their sacrifices on behalf of

Canada.” Realistically, the demand could only be met through co-operation with the provinces through negotiations that would be difficult. Building more beds for veterans depended upon provincial willingness to accept increases in their own long-term care budgets. To what extent Ottawa should subsidize provincial beds which ‘would be needed by veterans only for a few years of peak demand’ was by no means clear. Yet coming up with an answer to the bed shortage, the authors of the study argued, constituted ‘the single most important component of Veterans’ Affairs planning for the veteran population in its twilight years.’

The most puzzling aspect of this report was its explicit downplaying of the VIP’s role as the department’s answer to the potentially exploding costs of providing long-term care. For the past decade Veterans Affairs officials had argued that the department was ‘ahead of the field’ in developing an innovative community-based home care strategy as an alternative to building costly institutional care beds, a strategy which by the late 1980s was reaching its peak popularity. Fifteen per cent of eligible veterans were using the program by 1987. It was estimated that 45,000 would be doing so by 1991. Despite this success, a new department study was now arguing that more long-term care beds were needed, and lots of them. What, if anything, had gone wrong?

The VIP had saved money. 1200 beds that were expected to be in place by 1991 had not been built because of the freeze in new contract beds as a result of the program. On the other hand, the report also argued that ‘a conservative estimate’ of the number of veterans ‘currently needing institutionalization is in the range of 1100 to 1400,’ with waits of one to three years for entry. In other words, the numbers on the waiting list almost equaled the beds which had not been built since 1984. However well the VIP had

responded to maintaining veterans' self-sufficiency in the home, it apparently had not reduced previously estimated needs for additional long-term care beds. 'Pressures are mounting for increased numbers of long-term care beds because of the natural growth in the need for Type II (Nursing Home) and Type III (Chronic) care associated with the advancing age of VAC clients. It is equally clear that the demands for such care cannot be met solely through the VIP.'

Intuitively, it made sense that expanding home care alternatives should 'reduce requirements for institutional care.' The study argued that the VIP had indeed 'significantly reduced the demand for beds,' but the 'reduction is difficult to quantify,' since there was 'no known economic analysis that proves the quantitative relationship between the presence of home care and the savings from reductions in institutional beds.'

What does occur...is an easing of the demand for lower levels of institutional care. Patients who have been quietly suffering at home without assistance are now able to enjoy an improved quality of life and independent functioning. As well, stresses on the primary care giver, often the spouse or other immediate family member, are eased to make their lives more tolerable....However, demand for an already scarce supply of long-term institutional beds continues as the individual who can now be safely cared for at home is replaced in the queue by someone whose health care needs cannot be effectively provided at home.

The VIP, in other words, would 'not eliminate pressures for veterans' long-term care beds.' There was an 'urgent need' to build more of them. In the meantime, 'waiting lists

will continue to grow at an increasing rate and utilization of home care services will be extensive.’ This was not an argument advocates of the VIP within Veterans Affairs likely wanted to hear.

Ironically, despite its mandate to provide alternatives to institutional care, by 1988 the VIP was already funding the support of almost 1000 veterans in adult residential care facilities in communities across Canada, a situation the program had backed into more by necessity than design. When first created in 1981, the AVP gave veterans who needed help with the activities of daily living and lacked available family caregivers, the option of applying for support for accommodation within their communities in Type 1 residential care facilities, a category of assistance termed ‘Adult Residential Care’ [ARC]. The intention was both to reduce the pressure to supply greater numbers of more permanent departmental and contract beds and to widen the geographical availability of domiciliary care, since 40 per cent of Veterans Affairs district offices had no ‘designated veterans beds’ within their geographic boundaries. In the first four years of the AVP, when it was limited to a more affluent category of disabled pensioners, less than 100 veterans received ARC financed through the program. Once eligibility was broadened after 1984 to include a much larger and lower income WVA clientele, the demand began to expand significantly. In part this growth was fueled by an aging and frailer client population. But the very low personal cost of such residential care for veterans - which had been capped at \$120 a month since 1949 - was also an incentive. Payments were doubled to \$240 a month in 1985 in order to reduce the financial inducement to apply for institutional rather than home support but even this sum did not come close to defraying the real costs of adult residential care. ‘As long as the monthly co-payment is only \$240 there is still a major

economic benefit to the individual or the heirs in pressing for approval under the V.I.P.’ It was ‘an offer which is difficult to refuse for the veterans and for the next-of-kin,’ department officials pointed out, particularly since the low charge to families for care of their aging parent in such facilities ‘may generate a large estate for the relatives.’ Given the home care mandate of the VIP, this situation was especially frustrating. As one Ontario Region official argued:

Since the thrust of [VIP] is to keep veterans out of institutions, it seems anomalous to be ‘approving’ more institutions ..If we approve more facilities, we will be spending a lot more money on institutional care...Instead we should be seeking more money for home support services....[T]he bulk of our clients...will be old and poor. There will be a great tendency to use [VIP] to augment their meagre means. That is not [its] intent. Rather, it is to provide all the necessary supports to the veteran in his own home.

Headquarters in Charlottetown acknowledged the apparent contradiction but also pointed out that for a small category of VIP clients the increased need for ‘good quality long-term care beds’ was real and in the absence of a sufficient supply of licensed and inspected provincial facilities, there was little alternative but to allow field staff ‘to admit to otherwise good quality long-term care beds...that are neither licensed nor meeting appropriate provincial care standards.’ Nonetheless, this de facto ‘approval’ of unlicensed and unregulated adult care residences remained a source of much concern within the department throughout the 1980s. In most jurisdictions across Canada the licensing and

standards for Type 1 and even Type 2 facilities related ‘only... to safety and not care’ and in at least two provinces there was ‘no reliable provincial activity in this area at all’ Veterans Affairs officials acknowledged in 1985. Yet the overwhelming majority of veterans applying for VIP support for adult residential care did so from institutions in which they were already living making it “difficult for staff to ‘prevent’ a veteran from entering an unacceptable facility.” The situation was troubling to say the least. “The potential ...legal ‘fall-out’ should a veteran come to harm in a home which has been approved by us (but not by provincial authorities) could be disastrous,” regional staff pointed out. Yet the department lacked the resources, expertise, or jurisdictional authority to inspect or regulate such facilities in the absence of provincial action. ‘It would potentially require a small army of DVA inspectors to appropriately carry out the task,’ senior officials argued.

Some regions responded by simply refusing to pay for the costs of adult residential care, a position which provoked a stern reprimand from department headquarters since veterans were entitled to it under the VIP. Others tried drafting their own policy guidelines on the subject in response to ‘confusion concerning what are now acceptable institutions for this level of care’, a move which also provoked consternation in Charlottetown about regions rather than national headquarters making policy. The federal Justice Department simply advised Veterans Affairs to give families guidelines describing appropriate institutional care and let them make the choice as to where to place their parent or spouse. ‘The greater the distance between the Department and the actual decision concerning institutionalizing a veteran and the appropriateness of the institution, the less likely we are to be considered liable should the veteran be injured,’ officials argued in summarizing the

Justice Department position.’

By late 1986 Veterans Affairs headquarters finally drafted guidelines for regional offices to follow and also urged district staff to ‘tak[e]...a very hard look at all proposals for Type 1 admission’ and to make such admissions strictly according to the health and care needs of the client as determined by the district Health Care Team. Nonetheless, the uncertainties surrounding the department’s ability to actually monitor what took place within unlicensed and unregulated residential facilities continued to cause unease among district staff who worried that even putting their health care plans for veterans down on paper might ‘increase the risk of legal liability to both the department and the employees,’ especially since neither the department nor its service providers such as the Victorian Order of Nurses had any legal authority to conduct safety inspections of ARC facilities. To allay these fears justice officials insisted that the department did not ‘approve,’ but merely ‘designate[d]’ institutions where adult residential care could be provided. ‘T]he only responsibility of DVA is to ensure that the health care needs of the veteran are met.’ To some members of Veterans Affairs this was legal hairsplitting. How the health of their clients could be ensured if the safety of the facilities in which they lived could not be confirmed, remained unclear. These concerns combined with growing alarm at the rising costs of Type 1 domiciliary care and a strong sense that it was ‘contrary to our...philosophy of supporting and encouraging independence,’ would make ARC one of the most politically vulnerable components of the VIP during the next decade.

NOTES

Chapter 5

THE VIP, 1989-1993: CASELOAD EXPANSION AND FISCAL RESTRAINT

During the second half of the 1980s wider eligibility for the VIP, the aging of its clientele, and ongoing promotion of the program by Veterans Affairs staff, veterans organizations, and word-of-mouth publicity underpinned a remarkable explosion of its caseload and costs, during an era in which the Progressive Conservative government of Brian Mulroney was otherwise attempting to reign in social spending. 'The Veterans Independence Program is more popular than anyone could have realized,' officials within the department pointed out.

The impact of George Hees' motto of 'generosity, speed and courtesy,' which animated Veterans Affairs officials from head office in Charlottetown down to area counselors working within the department's 32 district offices, was reflected in the following statistical summary from a 1990 internal evaluation of the VIP which noted that 'over the past five years...the number of recipients has increased almost 730 percent (5500 in 1984/85 to 40,000 in 1988/89)...Program expenditures have risen 915 percent over the same period (from approximately \$6 million in 1984/85 to \$55 million in 1988/89). By year-end 1989/90 there were approximately 60,000 VIP clients, up 50 percent from 1988/89. Forecasts predict a healthy rate of program growth in 1990/91 to just under 90,000 clients.' Despite this healthy record of expansion the study also saw clouds on the VIP's horizon. Its aging clients would soon 'require a greater number of program elements and will also need more complex elements which place greater strain on delivery efforts.' All these trends were also occurring 'within the federal government

environment of resource constraint. Given that no new delivery resources are likely to help deal with increased program activity, the Department will soon be attempting to serve twice the number of clients with the same number of staff.'

The beginnings of this new and more severe climate of fiscal restraint took shape within the 1990 federal budget. In response to a rapidly worsening economic outlook, all government departments were instructed by the Department of Finance to suggest strategies for reducing expenditures for inclusion within the budget to be delivered near the end of February. Initially, department officials proposed they would administratively manage any reference level cut in their requested budget allocation for the upcoming fiscal year. Instead the department was told by central agencies that a more visible policy response was required. "Once it was clear a symbolic cut was to occur," Darragh Mogan later recalled, "the question at the time was, 'what made the most sense?'" Since veterans' pensions were virtually untouchable the search for savings turned to the VIP. The one element of that program 'judged to have the least effect on keeping clients out of institutions' and therefore not critical to its core mandate was a range of spring cleaning services called 'heavy housekeeping,' tasks such as shampooing carpets, washing walls and ceilings, or cleaning draperies, garages, attics, or chimneys. If something visible had to go, this was the service whose loss would be least onerous to the VIP's clients. As a result, the federal budget statement delivered on 20 February 1990 announced in passing that as of 1 April of that year the VIP would no longer pay for 'heavy housekeeping.' Regular housekeeping services such as laundry, vacuuming, cleaning floors and windows, dusting, bathroom and kitchen cleaning, meal preparation, and making beds, would continue to be available, on a needs-related basis. In all about 19,000 veterans were

affected by the cut, most losing up to \$500 a year. Savings were anticipated to be \$8 million in 1990-91 rising to \$10 million in the following fiscal year.

Groundskeeping and housekeeping, although by far the most popular parts of the VIP, had always been the elements most vulnerable to attack by central agency officials because they were viewed as the least health-related parts of the program. 'It is important to understand why [Veterans Services] made such efforts to have groundskeeping included as a benefit when the Central Agencies were urging it be abandoned,' senior department officials argued in the mid 1980s. 'We knew that many older people give up their homes because either they can't afford, or can't arrange to have the walkway cleared of snow or the lawn kept from becoming an eyesore.' Indeed, this was the core message of geriatrician Ferguson Anderson whose ideas had inspired the program. But the boundaries of those services proved hard to define. Almost as soon as the AVP was launched, regional staff began asking 'where are we to draw the line with respect to the upkeep of a person's home?' If housekeeping and groundskeeping included 'all those domestic duties and chores necessary to the upkeep of a home' did this also mean 'annual tasks such as cleaning and installing storm windows, eavestrough cleaning, and washing inside walls?' Were these chores also not 'essential to maintaining the home environment' which would 'deteriorate rapidly if they were not carried out?'

Initially Veterans Affairs headquarters argued against any routine inclusion of such 'heavy' housekeeping chores, with the exception of changing storm windows. A year later, as discussed previously, they attempted to limit all housekeeping and groundskeeping services only to pensioners receiving care for some other health-related condition, a decision rescinded in response to strong opposition from the War Amps of

Canada as well as protests from the department's own regional staff. Throughout the remainder of the decade debate continued on whether to include cleaning chimneys, repairing driveways, rolling lawns, cutting and/or stacking firewood, planting gardens, trimming hedges, exterminating pests, cleaning rugs, drapes, garages and attics, or even including condominium fees, as part of the groundskeeping or heavy housekeeping expenditures permitted for reimbursement through VIP. By 1990, as the program's clientele grew older and frailer, many although not all of these items, with some significant regional variations, did become elements of the program through a process some department officials termed 'policy creep.'

In the past the department had always consulted veterans organizations prior to planning or announcing any significant changes to programs affecting their members, which were normally announced separately rather than buried in the finance minister's overall budget statement. In the hasty lead-up to the cuts announced in Michael Wilson's 20 February 1990 budget this was not done, a decision department officials later conceded was a 'tactical error.' Veterans Affairs minister Gerald Merrithew, in a press release issued prior to the budget announcement, simply promised that it would have a 'relatively minor impact on programs benefiting Canada's veterans.' In relation to the department's overall level of spending on veterans, which totaled \$1.5 billion in the previous year, this was certainly true. What neither Merrithew nor his officials anticipated, however, was the symbolic impact of the cut itself which, as the Legion magazine quickly pointed out, represented 'the first abrupt budget cancellation of a benefit for veterans without warning or substitution.' As Veterans Affairs officials conceded afterwards:

the factor which...made veterans most angry was that the cuts were announced as part of the government budget! Their reasoning...was that if the system required corrections they should have been made on their own merits, and not included as a government plan to save money by cutting back on veterans. The method of announcement was seen as precedent-setting - in other words; if the Canadian people would accept cuts to veterans' programs for purely budgetary reasons, then nothing veterans had won over the years would be safe in the future.

This theme was seized on with alacrity by opposition members in the House of Commons and by the media who subjected Merrithew to withering criticism as soon as the budget cuts were announced. 'It is ironic that when Canada needed the service of brave and courageous Canadians our veterans were there. Now, when our veterans need the services of the Canadian government, it turns around and cuts assistance to them,' Cape Breton Liberal MP David Dingwall argued. Les Benjamin, Veterans Affairs critic for the NDP agreed:

I never thought I would live to see the day that government of any kind would attack veterans....Every member of Parliament in every year...[has] agreed...that we will never be able to fully repay them. It was sacrosanct. It was not as much as we could do or should do, but it was the minimum we must do. Now we have the obscenity of this mealy-mouthed, chiseling of our war veterans. I do not understand it...If this country and this government are that hard up and that desperate that they have to pick on our veterans, there is something wrong with

our priorities, particularly the priorities of the government.

Heavy housekeeping was ‘an essential service’ to veterans whose average age was now 70, Fred Mifflin, a retired rear admiral and Liberal MP from Newfoundland argued. ‘This \$18 million cut is counter to the aim of the program...which is designed to care for them at home.’ When Merrithew responded haplessly that overall spending on the VIP had increased by 60 per cent over the past year and was expected to double over the next four years, Mifflin zeroed in for the kill. ‘No matter what the minister says, the fact remains that money was taken away from veterans and benefits were cut. *Something is being taken away from veterans for the first time since the great depression.* We should not be taking something away from veterans, we should be racking our brains trying to find something to give them.’ In response the beleaguered Veterans Affairs minister could only promise that ‘where there is a legitimate health or safety requirement on the part of a particular client for the provision of a service presently found under heavy housekeeping I... will ensure that service continues to be provided to the veteran in need.’

Throughout March and April a storm of grassroots anger from veterans against the elimination of heavy housekeeping took the department’s regional offices, headquarters in Charlottetown, and the leadership of veterans organizations themselves by surprise. In Sydney Cape Breton over 400 veterans took to the streets for a protest march to the regional Veterans Affairs office in order to condemn the sudden change. Leaders of the local Legion branch told CBC that ‘veterans will not accept the cuts and [that they] expect [ed] the protests to swell across the country. In alarm, department headquarters asked its regional offices across the country to report on the volume of calls they were receiving

about the cutback. The response was over 4000. North Bay ‘stopped counting after 500 calls.’ The Sydney office reported receiving a similar number. Two common themes emerged in clients’ complaints. A large number feared that all of their housekeeping services, rather than just heavy housekeeping, were about to be taken away as well as ‘shock and panic’, as the London Ontario district office put it, “that government ‘dares to do this to veterans’ and confusion and fear as to what will be cut next.” As reports from districts offices continued to filter back to Veterans Affairs headquarters, officials also began to realize the extent to which they had miscalculated the uneven regional impact of the cut. In Cape Breton, site of the most vigorous protests, for example, it became clear that

we hadn’t understood the cultural aspects of what we were doing. ‘Heavy Housekeeping’ on Cape Breton meant ‘wall washing’. Every spring, most elderly Sydney residents wash down every interior wall in their houses. And the reason is more traditional than practical; it started with the constant coal dust in the air from the mines. Media stories concerned First and Second World War Cape Bretoners tottering back and forth on step ladders and not a lot of imagination is needed to conjure up the picture in the public mind.

In other parts of Atlantic Canada, rural Quebec, northern Ontario and the prairies, district offices reported that large numbers of their clients had wood burning stoves and therefore required the removal of ‘soot and smudge from ceilings and floors’ in the spring, as well as their chimneys cleaned. ‘It the common practice of people in the region to clean pipes

themselves by dropping heavy chains down the chimney to reduce...buildup. As the clients age they are no longer able to perform this task themselves but must rely on others.' In pulp and paper towns across northern Canada counselors also pointed out that ash from forest fires as well as a "constant emission of wood fibre into the air as a grey film...and a 'rotten egg' odour enters a house, clinging to walls, furniture, carpeting and becomes trapped in forced air heating systems' aggravating respiratory and eye problems. Prairie counselors underscored the after effects of dust storms, crop pollen, and airborne pesticide spraying in their clients' homes. Other counselors noted that for a significant proportion of their caseload heavy housekeeping was the only VIP benefit being received, and so it often provided a critical gateway into full treatment benefits. The cost of losing it would be devastating.

By offering the Finance Department a 'symbolic' cut for small and possibly illusory savings, Veterans Affairs had in fact created a public relations nightmare. In early April, deputy minister David Broadbent conceded as much to Merrithew by noting that 'our basis for canceling heavy housekeeping was flawed in the extreme...[T]o deny, for example, the washing of walls, particularly in areas of heavy pollution, is to withdraw a type of service that is needed much more by a frail elderly veteran than the lighter types of regular housekeeping.' These actions were 'likely to cause a good deal of hardship, not to mention political difficulty.' Indeed, it seems clear that when he approved the cancellation of heavy housekeeping, Broadbent himself was operating under the mistaken impression that all clients receiving it were also being provided with regular housekeeping through the VIP, a circumstance which would have minimized the impact of losing spring cleaning. This turned out not to be the case, as the unexpected volume of protest revealed. 'We just

do not have the rational argument that we thought we had initially for canceling heavy housekeeping,' Broadbent told Merrithew two months after the decision had been announced. 'It is obviously a great aid to clients who can manage most day to day tasks in their homes but are incapable of climbing ladders and handling buckets of water to wash their own walls. There is a risk if this issue does not die away because we really do not have a solid argument for saying why it should be deleted.'

Nor was it likely to die away. 'Of all the cutbacks and savings announced [in the 1990 budget] only ours actually removed money or other benefits from individuals,' department officials subsequently argued. 'The media had something of a field day, and veterans were outraged at being the only Canadians asked, as individuals, to do their part in reducing the deficit.'

Two options remained. One was to simply admit a mistake had been made and reinstate heavy housekeeping. However, this was ruled out as undermining the credibility of the entire cost containment exercise. The other was to provide the same services on a non-routine basis for 'health and safety' reasons as part of the regular housekeeping provisions of the VIP. Since Merrithew had already promised in Parliament that no veteran with a 'legitimate' health or safety need for heavy housekeeping would be denied it, the second option was chosen as a face-saving retreat.

Discovering who fell into this category, though, was not easy. To live up to Merrithew's pledge, district offices across the country were given the time-consuming task of reviewing the files of all their clients who had been receiving heavy housekeeping to determine whether its loss would pose a threat to their health or safety. Since not all districts knew exactly who had been receiving it, in some offices this meant reviewing all

their case files. Nor was it clear how the risk to health and safety was to be interpreted. If it came from elderly and disabled veterans trying to perform these tasks on their own, most would need to have heavy housekeeping reinstated. If the threat was simply the absence of services themselves, relatively few would see heavy housekeeping restored through the VIP.

War Amps' president Clifford Chadderton clearly interpreted Merrithew's promise the first way. Indeed, as assistant deputy minister Serge Rainville later pointed out, 'discussions between Health Care staff...and Mr. Chadderton make certain that...as far as the War Amps are concerned, they were promised that all their members would be exempt from the cancellation of Heavy Housekeeping in the February 1990 budget....This commitment was likely given at the political level, but it was not communicated to any staff working on the Heavy Housekeeping policy.' As a result, in a letter sent to all War Amp members at the end of May 1990 Chadderton argued that in the light of Merrithew's statement in Parliament, "the policy now is that... heavy housekeeping may be paid if, to carry out such chores, would jeopardize the 'health and/or safety' of the pensioner." Since it seemed obvious to Chadderton that Veterans Affairs did not expect amputees to be balancing on ladders cleaning eavestroughs, changing storm windows, or washing ceilings almost all War Amps who were previously in receipt of heavy housekeeping would be able to have these services reinstated.

However, this was not the interpretation used by Veterans Affairs. Instead, the department's new guidelines restated the doctrine of familial responsibility for caregiving which underpinned the VIP. Both the veteran *and* his or her spouse had to be incapable of performing the tasks of heavy housekeeping to create eligibility for the service. Nor was

this all. The absence of the service, not the risk to the veteran or his spouse in performing it, would determine whether or not it would be provided on the grounds of ‘health and safety.’ Washing walls and ceilings, for example, would only be restored under three conditions: if there were environmental concerns from smoke, dust or pollution; if the veteran had a health problem such as an allergy or respiratory ailment which would be aggravated by such conditions in the home; *and* if neither the veteran nor spouse could do the work.

Once the subtleties of the department’s new guidelines on heavy or ‘non-routine’ housekeeping were made clear to veterans organizations, they protested loudly. “Why [should] the Department expect a spouse to provide these needed services as ‘free labour?’” the Legion argued. ‘Especially since, until a very short time ago, such services, when provided, were immediately curtailed upon the death of the veteran.’ The War Amps were even more outraged at the perceived betrayal of their anticipated exemption from the cutback and by the notion that their wives should now be expected to change storm windows, clear eavestroughs, clean chimneys, or stack wood, tasks traditionally ‘performed by the male in the family.’ The only condition governing eligibility for heavy housekeeping, Chadderton argued, should be the health risk posed to the disabled veteran from attempting to perform these tasks himself. Despite some internal debate, Veterans Affairs refused to budge, although Merrithew told his staff to apply the policy ‘leniently or with sensitivity.’

The Legion’s leadership agreed, reluctantly, that they ‘could live with the proposal.’ The War Amps could not. Indeed, over the history of the VIP no other issue generated such acrimony between that organization and the department. Apart from

feeling misled, the War Amps' anger also stemmed from their particular sense of entitlement to the VIP. Disabled pensioners, having suffered most due to war service on behalf of Canada, were at the top of the complex benefit system provided through Veterans Affairs, a status seemingly confirmed between 1981 and 1985 when they were only group to receive services provided through the AVP pilot project. Indeed, when the program was extended to the larger category of low-income WVA recipients in 1985, the War Amps argued, unsuccessfully, that the VIP should be broken into two separate components, one for disability pensioners and the second for 'WVA and others' so that issues of pensionable entitlement and financial need would not be confused.

As long as benefits provided through the VIP were expanding throughout the 1980s this tension remain muted. When heavy housekeeping became the first cutback to hit veterans since the 1930s, it rose again quickly to the surface. 'Comparisons are odious,' Chadderton admitted, but the fact remained that under Veterans Affairs new health and safety guidelines, 'non-pensioners...even though they had no overseas service, but who are suffering from systematic diseases such as asthma and emphysema' could continue to receive heavy housekeeping services through the VIP while thousands of his highly disabled members, 'a group of veterans who gave the most in the service of their country,' no longer could. In the eyes of War Amps, this was simply unacceptable. 'While it may be true that under VIP regulations, there is no difference between the War Disability Pensioner and the Income Qualified veteran, this is not true in the mind of the public, or under other statutes administered by the Department.' Disabled pensioners had been used as the "so-called 'lever' or 'foot-in-the-door'...to obtain the necessary approval from government [for the VIP]" since they had an unchallenged right to a long-term care

bed financed through Veterans Affairs. 'Non-pensioners have a different criteria for admission' which did 'not represent the same recognizable grounds for admission as a time-honoured concept: i.e. that the Government of Canada must provide institutional care for those veterans who require such as a result of conditions which arose from military service to Canada during a time of war.'

To officials responsible for the VIP, however, this was a flawed understanding of the fundamental purpose and philosophy on which the program rested. Since the VIP was based on need, not right, there was no reason why disabled pensioners should be specifically exempted from the cancellation of a service, such as heavy housekeeping, whose loss also affected all other clients of the program. As Darragh Mogan argued, 'the facts remain, and it is very difficult for the War Amputations to accept this, that the cancellation of heavy housekeeping was categorical. It does not exist anymore. The exception was made for a category of needs and circumstances, not a category of veterans.' Nor was it clear that the loss of heavy housekeeping had had a major impact on the VIP's clients. After an admittedly rocky start, over the following year district staff were able to ensure that all those in receipt of heavy housekeeping were put onto regular housekeeping, and those who required 'non-routine' services for health and safety reasons were receiving them. Although the War Amps continued to argue vigorously over the next two years for the restoration of heavy housekeeping to their members, claiming they had hundreds of examples of members experiencing difficulties, department officials claimed that their requests was coming at time when field staff were saying 'Leave it alone, it's not a concern of veterans. It has finally settled down, don't stir it up again.' Assistant deputy minister Serge Rainville also felt 'strongly that a change would seriously damage

our credibility with both veterans and Departmental staff as we would be seen to be caving in to pressure on a matter of stated Government policy,' endangering the entire fiscal restraint exercise.

Chadderton, however, refused to back down, and continued to lobby Veterans Affairs with new proposals aimed at reinstating heavy housekeeping for his members. He first called for the restoration of heavy housekeeping to 'any veteran...in receipt of a disability pension of at least 80%' or who was blind, paraplegic or had experienced a major amputation, or was receiving attendance allowance at grades 1,2, or 3 level care. The impact of this recommendation, department officials argued, would be to reinstate heavy housekeeping for some 6000 clients of the 19,000 clients who had lost it in 1990, contradicting the budget decision that the service had been cancelled. To discredit claims by Veterans Affairs that no pensioners were at risk from the loss of heavy housekeeping, the War Amps forwarded 'test cases' of appeals from amputees who had suffered injuries from falls occurring during their attempts to perform spring cleaning. The chores might have been risky for amputees to attempt, department officials replied, 'but there [was] no demonstrated health reason why they should be done.' To accede to such requests would 'have the effect of reinstating heavy housekeeping for all veterans.' The War Amps also wrote to all their members pointing out that Veterans Affairs field staff were claiming 'Heavy Housekeeping is no longer a problem. In the event that your request is denied, please write or phone...and we will be happy to appeal the decision.' This mass mailing generated a new wave of rejected applications from unhappy veterans.

As a compromise Chadderton tried a new approach calling for the restoration of heavy housekeeping services to their members subject to a \$250 annual limit, rather than

the \$500 average cost previously in place before the 1990 budget. To help resolve a discussion which by now seemed 'endless,' Darragh Mogan and assistant deputy minister David Nicholson negotiated a draft policy guideline for implementing a \$250 annual cap on heavy housekeeping for each War Amp, 'only on the condition that broad publicity of this exemption by the War Amputations Organization would not be undertaken.' It was sent to the deputy minister David Broadbent in June 1992 but was never approved.

By the spring of 1993 the exasperation of the War Amps over the lack of progress on restoring heavy housekeeping for their members had reached a peak. In April Cliff Chadderton sent a 22 page brief on the topic directly to Veterans Affairs and Defence minister Kim Campbell recapitulating, from his point of view, the frustrating history of negotiations on the topic and expressing 'shock and dismay' that the department had closed the door to further discussion on 'a battle which has been raging for more than three years [to restore] a significant benefit which was taken away from a group of veterans who gave the most in the service of their country.' By this point Chadderton had won support from the Canadian Legion on behalf of his campaign. Soon he would announce his intention of launching a Charter court challenge around it as well as inform Veterans Affairs officials that he was in negotiations with the CTV news affairs show 'W5' for a program on the topic planned for 'their new fall schedule.' His political timing could not have been better. The department's minister, Kim Campbell, was actively seeking the Progressive Conservative party leadership to replace the outgoing Brian Mulroney. Within two months she would become Canada's first female Prime Minister facing an election which could not be postponed past the autumn. The spectre of media attention on disgruntled war veterans within her portfolio was clearly not appealing.

More importantly Chadderton's brief contained another offer. This time the War Amps asked that heavy housekeeping be restored only to pensioners with a 100 per cent disability, a variation on their earlier proposal of two years ago. This was 'a significant compromise on their part,' Darragh Mogan argued, 'that will allow this long standing irritant to be settled.' Since the exemption would apply only to the most disabled pensioners, it was 'unlikely other Veterans Organizations would object.' In total it was estimated that about 2400 pensioners on 100 per cent disability within VIP would see their heavy housekeeping services restored at a cost of \$720,000 annually if the War Amps proposal was approved.

As a means of bringing closure to a longstanding battle between the War Amps and Veterans Affairs, Chadderton's proposal was now viewed by senior department officials as 'very attractive.' By the end of July 1993, despite some last minute acrimony on Chadderton's part, and unhappiness among Veterans Affairs district staff that the department was 'bowing to political pressure' by 'reversing its position on this policy,' the framework of a deal was in place. Class 1 100 per cent disability pensioners who were also in receipt of Exceptional Incapacity Allowance or Attendance Allowance or both and who needed heavy housekeeping would see it restored as of 1 November 1993. All pensioners in this category who had lost this benefit in 1990 would be contacted and reinstated if they so wished. Otherwise the agreement would not be publicized by the War Amps who agreed to keep communications on the topic 'low-key' and 'promise[d] not to advertise a victory.'

Apart from demonstrating the political pitfalls of attempting to implement cutbacks to veterans benefits or services, the bitter three year conflict between the War Amps and

Veterans Affairs over heavy housekeeping also underscored the difficulties of balancing competing tensions of entitlement and need within the VIP, and in coming to terms with the growing frailty of its clientele and their caregivers. War Amps, who appreciated assistance coping with the more difficult seasonal tasks of independent living when they were in their sixties, were hardly willing to forego these same services once they were ten years older and frailer. ‘The question here is not whether the failure to clean the rugs and drapes, and do other heavy housekeeping chores, would prejudice the health and safety of the pensioner.’ Chadderton argued in his major brief on the topic. ‘The question...is whether the failure to do...the chores would mean that the pensioner could no longer live in his own home.’ This, after all, was ‘the original purpose of the Aging Veterans Program.’

Veterans Affairs officials, on the other hand, forced by the 1990 budget restraint exercise to make ‘the best of bad choices’ chose the elimination of heavy housekeeping as a ‘symbolic’ cut which appeared to do the least harm to their clientele. Once the decision was made, implementing its effects equitably among all VIP recipients based on principles of client-centred need rather than pensionable entitlement was deemed essential to the integrity and rationale of the program, as well as to the credibility of departmental headquarters and the entire ‘policy creep containment strategy,’ among its district staff. Symbolic cuts, however, provoke symbolic responses. To disabled pensioners who viewed their primacy in the Veterans Affairs hierarchy as ‘indisputable’, the very fact that any reduction in services was being implemented, particularly as they and their spouses grew older, was an unacceptable step in a direction they were simply not prepared to go. It was a lesson that would not be soon forgotten within the department.

The climate of deepening fiscal restraint which provoked these first program cutbacks to veterans also triggered other major transformations in the way the VIP was administered. The first was a movement away from reimbursing clients following submission of receipts to a process of 'advance pay' through which veterans were given cash up front to cover the most common monthly costs of housekeeping, groundskeeping, and social transportation. Providing money in advance without receipts was a highly unusual and potentially risky administrative process for a government contribution program such as the VIP. However, throughout the late 1980s an exploding caseload was placing tremendous administrative pressures on staff at the district, regional, and national level. As the number of clients jumped twelvefold between 1985 and 1990 and expenditures grew by a factor of 18 from \$6 million to \$109 million annually, Veterans Affairs headquarters received increasing complaints about lengthy delays of six to eight weeks in reimbursing veterans for their 'out-of-pocket' expenses. Almost a quarter of VIP clients reported that these long delays were 'causing hardship' and forcing some to leave the program 'because they can't afford to finance the Department of Veterans Affairs.'

The demands of processing almost 600,000 invoices for small routine expenses such as grass-cutting and house-keeping were also taking a toll on staff morale at the district and regional level, and were also becoming increasingly difficult for an aging and frailer VIP population to manage. "Clients were encouraged to negotiate their own service provider, pay for the service themselves, and forward the receipt to the district office for reimbursement. These receipts varied from services provided by the 'boy next door' to others which were invoices from landscaping companies and nursing homes. This resulted in a hodge-podge of documents being received." As one internal study of the VIP argued

anecdotal evidence from the field suggests that there are a number of Counsellors and Program Support Clerks who are burning out because of high client numbers and an over-controlled delivery environment....Almost 50% of cases studied reported Counsellors currently suffering from health problems... directly or indirectly attributable to work. Some Counsellors are so frustrated that they are actively seeking employment elsewhere.

Legion officials also reported that ‘veterans are angry about delays in receiving their cheques.’ ‘It would be inexcusable,’ assistant deputy minister Donald Ferguson argued in 1988, ‘to see VIP, a totally viable and creditable program, undermined because of severe administrative weaknesses.’ With an anticipated doubling of the VIP caseload between 1990/91 and 1995/96 to 120,000 clients this labour-intensive process of administration ‘seriously threaten[ed] the viability of continued program delivery’ unless its staff could “‘identify ways to ‘work smarter.’”

In order to find ways of getting money faster to low-income clientele on an ‘emergency’ basis, Veterans Affairs officials had sought and received Treasury Board approval in 1987 for flexibility to allow advance VIP payments for veterans subject to a counselor’s estimates of their monthly financial need, although central agency officials warned ‘it should be avoided as much as possible.’ The idea was to be tested first in the prairie region as a pilot project between 1988 and 1989 but nothing was done because of ongoing major changes to the department’s financial management and caseload software. With the software problems finally resolved, Darragh Mogan was ready to push for the

implementation of advance pay on 1 January 1991 'as a last resort...[which] would not be used often' for the VIP's low-income clients when it was 'reasonably certain that the veteran will be able to manage the advance and use it for its intended purposes.'

Nonetheless, the proposal did not go forward at that time because both Treasury Board and the Office of the Comptroller-General refused to allow the random auditing of client invoices required to achieve real administrative savings.

The February 1992 budget, which as part of a larger federal government restraint initiative required all departments to submit proposals for both reducing costs and improving services to clients, changed the political urgency, rationale, and intended scope of the proposal. As part of 'the intense executive level discussions on what to submit as VAC's contribution to the Budget' department officials singled out advance pay for VIP clients as the idea with 'the highest probability of success.' There was already a clearly identified need to do something to reduce delays in getting payments to clients, to reduce their out of pocket expenses, and to find ways of coping with rapid caseload growth over the next three years in the context of no new staff. If advance pay was extended to most veterans on VIP rather than used only as a last resort, as initially planned, it had the potential to cut the administrative costs of processing over 600,000 invoices each year by 75 per cent. This could free up anywhere from 61 to 84 person years of employment to help meet an anticipated shortfall of 130 district counselors by 1995-96.

As an added incentive, Treasury Board was now willing to authorize a random sampling of client receipts for purposes of post-audit verification, similar to the process used for monitoring income tax returns. Once shifted to advance pay, VIP clients would be provided with quarterly payments in advance to cover their anticipated housekeeping,

groundskeeping, and social transportation costs and would no longer be required to submit invoices for reimbursement. Instead they would only be asked to retain receipts for verification purposes on request. Advance pay was ‘essentially good news for clients (increased autonomy, no delays for reimbursement, no paper burden), but bad news for staff whose roles and work locations will change as resources are redeployed,’ senior officials argued. As a result,

these two audiences will require very different communication strategies: clients may be enthused about increased autonomy but will need clear instructions on how to deal with the new payment process;...staff may be threatened with job loss or relocation and will need reassurance about maintaining service to clients by redeploying resources.

The ability to manage both client expectations and staff morale would also clearly be affected by the speed and process through which advance pay was implemented. The traditional strategy, which had been used by Veterans Affairs for most of its major initiatives, was the regional ‘pilot project’ model which had already been suggested in 1988, but was not used. A second approach was to phase in advance pay gradually over a three year period as client contribution agreements came up for reassessment or renewal. This approach would ‘allow the bugs to be worked out’, department officials realized, and provide more time for staff training and effective communication and consultation with veteran clients and their organizations. Although ‘seriously considered’ it too was rejected. At bottom, both the pilot project and gradual phase-in strategies suffered from

the same political weakness. Neither would realize major fiscal savings in the upcoming budget year which was a key goal of the exercise. Instead, the decision made in February 1992 was to implement advance pay simultaneously in all regions as of 1 July, a date subsequently postponed to 1 September in order to give regional and district offices slightly more time to prepare. In this way, senior officials argued, “should there be any difficulties the ‘pain’ occurs once rather than continuously.” Almost all clients were to be put on advance pay unless there were compelling reasons for them to remain on the previous reimbursement system.

Client confusion and declining staff morale, particularly from fear of job losses, were two key risks of this quick national implementation strategy. Staff morale had already been identified as a key problem by the 1991 VIP evaluation study. Further erosion was particularly worrisome since one of the key outcomes of the switch to advance pay was the need to ‘rely heavily on counselor assessments - even more now than before. Previously we paid the amount of a receipt after services were received. Now payments will be in advance, on the counselor’s assessment and judgement. The counselor is the front end control.’ Treasury Board had made it clear that as a result of advance pay ‘program expenditures cannot be allowed to increase.’ Whether this occurred would depend on how well counselors used their increased discretionary authority to keep their estimates of clients’ needs from ‘gravitat[ing] to the program limits.’

Directors from some regions warned this was exactly what was likely to happen. Precisely because of the workload demands placed on counselors ‘there will be a natural tendency to estimate amounts for the first year...on the high side in order to reduce the possibility of future amendments.’ District counselors had previously been encouraged by

management to provide clients with a 10 per cent 'cushion' for approving reimbursements in order to get them safely through the year. 'This mindset must be turned around,' Veterans Affairs officials argued, or the costs of advance pay would soar. There were also 15,000 clients already in the system for less than one year for whom complete costing data for making advance pay estimates were simply not available. Over the summer of 1992 district counselors began sending in their advance pay recommendations for clients in anticipation of the 1 September startup date. By mid-July it was becoming clear to regional offices and national headquarters that the conversion to advance pay was 'going to produce an unacceptably high increase in VIP expenditure' and that if this pattern was extended to the total client population 'intolerable increases in expenditures would result.' As a result, national headquarters staff quickly began revising downwards many of the counselor recommendations without telling district staff.

On 1 September 74,000 VIP clients received a letter announcing that Veterans Affairs had developed a new advance payment process 'to serve you better' and that the 'change in the payment process does not affect you.' When the cheques arrived, however, thousands of veterans discovered that the monthly amounts their counselors had promised, were not in fact what they had received. The result was confusion and outrage. Within a week of the advance pay cheques going out, department staff logged over 10,000 phone calls nationally. The most frequent complaints, regional staff reported, were that clients did not understand the new system, did not understand why they were getting less than what their counselors had promised, or 'were not getting the amount they need.' 'Some are saying to forget advance [payment], they want to go back on reimbursements.' Members of Parliament wrote to Veterans Affairs headquarters complaining they were

‘quite frankly... at a loss to explain to the Veterans how the various amounts were arrived at.’ District office staff across the country reported feeling ‘overwhelmed, frustrated, and potentially burnt-out’ in coping with the volume of protest. One prairie region official summed up the reasons for the anger permeating his office:

The process was financially driven rather than driven by need as assessed by the case managers...All of this has made it very frustrating for the staff. With the numerous discrepancies they feel their hard work was in vain....This whole process has caused a tremendous burden on the districts’ workload. A majority of the inquiries were because the amount of the advance payment was less that what was discussed with the counselor. Most of the counselors feel that this has put their credibility in question with their clients. It has also put the department’s credibility into question. The trust level among the staff has also been put to question...There is a general feeling of betrayal...To be completely honest, many staff feel that Head Office is to blame for the problems they are experiencing.

Within a week of advance pay’s implementation senior officials at Veterans Affairs headquarters were in despair. ‘Where has a potentially good news story both for clients and for staff gone sour?’ acting deputy minister Dave Nicholson asked? A ‘post mortem’ inquiry team was appointed to find out what had gone wrong.

As the autumn of 1992 wore on it became increasingly clear that advance pay was threatening to become a major fiscal embarrassment. The ‘quick fix’ approach, taken during the late summer of trying to make unilateral adjustments to counselor

recommendations, could not be sustained particularly given the sheer volume of cases, totaling over 55,000, that had been switched to advance pay, and the anger of district staff at seeing their credibility as case-managers undermined. By mid-November, however, expenditure forecasts for the VIP, as a result of the switchover to advance pay, were alarming. Prior to the conversion, per client costs ranged between \$1200 and \$1300 a year. Once these same veterans were placed on advance pay, their VIP payments averaged \$1750 per client per year, an increase of 40 per cent. Projected to the end of the current fiscal year, advance pay alone would push VIP expenditures \$13 million above budget reference levels. Over the following fiscal year 1993-94 the unanticipated cost increases traceable to advance pay were forecast to hit \$25 million. And even this figure could be an underestimate, Darragh Mogan warned. This was not good news. A measure implemented as part of a fiscal restraint exercise was instead costing the department far more, while at the same time creating 'a good deal of anger and disappointment' among both clients and staff. In retrospect, Mogan noted, it was clear that 'use of a pilot project and/or phased-in approach to implementation, had either been possible under the circumstances of the Budget, would have been a much preferred method of implementation.'

The post-mortem report on the implementation of advance pay, delivered at the end of December 1992, spelled out clearly what had gone wrong, how it could be fixed, and what Veterans Affairs could learn from the experience. In a nutshell its authors argued that, although there was nothing wrong in principle with the idea of advance pay, the timing and method of implementation had been flawed from the outset. Since advance pay was included in the federal budget, the need for confidentiality severely limited the degree of consultation that would 'normally be expected for a change of this magnitude.' As a

result, key problems could not be anticipated, and flawed assumptions could not be field tested. The decision to rush into a full national implementation by 1 September also resulted in a major underestimate of the significance of the change for clients and staff as well as the time required to train counselors or to get them to buy into the project, let alone resolve problems which began to occur once it was being implemented. Advance pay was simply 'too complex and too dramatic' a change to be 'implemented quickly.' The training sessions were 'too short', were 'weak on specifics' and provided 'minimal follow-up...to ensure the message was received.' The department's data management software was also not up to the task of providing counselors with the timely information they required to make accurate forecasts of client needs. Experience also demonstrated that the proportion of the client caseload suitable for advance pay was also greatly over-estimated. District staff argued that anywhere from 35 to 75 per cent of their clients were better left on the reimbursement system. The department also failed to anticipate that clients provided with money up front for housekeeping, groundskeeping, transportation, nutritional and personal care expenses, were likely to use these services more often and therefore reach the maximum amounts provided in their care plans.

The key message of the report, however, was the need for major reforms in the way Veterans Affairs headquarters implemented change and in the way district staff accepted accountability for change. A year before advance pay was launched the VIP process evaluation study had warned that in the face of increasing workloads as well as a 'wide array of inflexible procedures and management controls' delivery staff were 'becoming frustrated with the process and are losing belief in the appropriateness of what they are asked to do.' Nothing which transpired during the implementation of advance pay

reduced these concerns. Instead, as the authors of the post-mortem report observed, ‘the controlled anger and frustration by the staff interviewed during this study was evident,’ particularly over ‘quick fix’ decisions by head office to ‘overturn recommendations that had been negotiated between the counselor and client. In the eyes of the counselor there was a significant loss of trust, credibility and respect.’ On the other hand, it was also clear that giving district counselors more discretionary authority over expenditures at the field level involved trade-offs on their part as well. ‘There has never before been an awareness of accountability built into the management of VIP program costs,’ the authors argued. This clearly had to change. ‘If we are to have any hope in the future of controlling expenditures we must provide these staff with a clear understanding of what is expected of them.’ As a first step, the department had to ‘go back and provide the training, education, and ongoing support that was missed’ when advance pay was being implemented. It also had to devise an ‘accountability model’ based on collaboration between finance and program managers that could identify the expenditure increases which were causing the greatest concern, and develop the tools, the training, and the commitment to act upon them. ‘Staff have to understand the change, buy into the change, and be held accountable for the results.’

Over the next eight years advance pay would prove to be a mixed success. By eliminating the need for clients being ‘out of pocket’ for routine expenses, it was clearly a boon to low income recipients of the VIP which was, after all, one of the key original goals of the initiative. It also reduced the complexity of administering the program, although not nearly to the extent anticipated. By 1996 over half the program’s clients had returned to the more familiar reimbursement model, a far cry from the original expectation

that 95 per cent would be on advance pay, in part because of annoyance with increased administrative controls put in place to maintain fiscal accountability. Throughout the remainder of the 1990s annual post-audit verifications of the system also revealed ‘critical error rates’ in client accounts ranging from 10 to 37 per cent of the cases examined. As the department itself conceded, by the decade’s end ‘due to workload pressure within...field offices associated with an ageing clientele...few audits of receipts are being conducted’ even though program costs for advance pay, on average, were ‘more than \$1000 per client more than for VIP reimbursement’ as a result of what head office staff suspected was ‘additional padding.’ In short, many of the original concerns of the post-mortem implementation study had by no means disappeared. Nor was there any conclusive evidence that advance pay had saved the department the predicted 40 person years of staffing. A bigger problem, however, was simply the aging of the VIP’s clientele. As veterans grew older, their capacity to keep track of the many low-cost receipts required for the post-audit purposes of advance pay had deteriorated although their worry of being held responsible for overpayments remained. As a subsequent study put it, ‘although the onus on clients for out-of-pocket expenses has been eliminated, it is questionable whether VIP has truly been simplified for [them].’ Counselors also expressed considerable frustration at being placed in the role of ‘account managers’ with responsibility for policing the veracity or bookkeeping efficiency of their elderly clients when their time could be better spent concentrating on the health needs of a high risk caseload. As a result, few within the department were disappointed when, in April 2003, all VIP claims administration was integrated into a single processing system provided by a separate contractor and advance pay came to an end.

Cost-containment pressures on the VIP, which began with the cancellation of heavy housekeeping in 1990, intensified even further in 1993 when Veterans Affairs was required, as part of a new federal government fiscal restraint exercise announced by Finance Minister Don Mazankowski in December 1992, to make a further 10 per cent cut in projected spending on the program in each of the following two years. Within an approved VIP reference level budget of \$192 million this meant finding ways of eliminating \$19 million from anticipated spending for each of the 1993-94 and 1994-95 fiscal years. Making an already difficult situation much worse was the unanticipated cost over-runs from the implementation of advance pay which, on its own, was projected to create budget short-falls within the VIP of \$12.2 and \$26.5 million respectively over the same two year period. The combined totals of the 10 per cent cut and the advance pay cost over-run left the VIP facing a significant fiscal gap of \$31.2 million for 1993-94 and \$45.5 million in the following year.

Coping with a budgetary challenge of this magnitude required more than simply minor cuts and administrative changes, the new Veterans Affairs minister Kim Campbell argued. It also demanded a major shift in organizational culture away from the George Hees' legacy of the late 1980s. 'A basic issue will be staff attitudes and their ability to deliver the cuts,' Campbell warned her cabinet colleagues. 'It will require considerable time and money to alter the culture of courtesy, generosity and speed which has been inculcated in our staff and has, in the past, characterized Canada's relationship with its veterans. We must now turn that attitude around to reflect fiscal reality, while at the same time not alienating the powerful and deserving veteran constituency.'

To help with the difficult deliberations around cost reductions and the move

towards a new departmental philosophy of expenditure control rather than program expansion, a new Field Advisory Committee was created in January 1993, composed of representatives from the regional offices and national headquarters. Upon the advice of the FAC, the department agreed to implement the reductions within the VIP through five key changes. Accommodation and meal rates for long-term residential care would jump 29 per cent from \$420 a month to \$541.50, the lowest provincial rate currently in operation, a measure which would impact 6000 veterans. Eligibility control for low-income clients and so-called 'near-recipients' would be policed much more vigorously, through the use of new computer technology. Twenty thousand near-recipients, who would have been receiving a War Veterans Allowance if they were not already in receipt of OAS/GIS, would now have their incomes checked yearly with the expectation that 8500 would lose their treatment benefits and 3000 would be cut off from the VIP. The longstanding Attendance Allowance/VIP overlap, discussed previously, would finally be eliminated. As a result, veterans in receipt of this allowance for personal care through the pension system would no longer be eligible to access similar benefits through the VIP, a measure expected to affect 1300 highly disabled veterans. No new clients would be accepted into Type 1 Adult Residential Care, a benefit cut which would impact two hundred veterans a year. Veterans already receiving such care would remain unaffected. Finally, district counselors would now be required to enforce cost ceilings as well as eligibility for the VIP more rigorously. Payments for summer groundskeeping, for example, were to be pared back. The eligibility of pensioned veterans for VIP services would also have to be 'clearly linked to war-related disabilities' as was the case in the earliest years of the program. The proactive philosophy of ascertainment was also terminated. Henceforth there would be 'no

advertising or active searching for new clients.’ Combined with other non-VIP related cuts for drug benefits and burial expenses, the proposed changes were expected to save \$39.3 million in 1993-94 and \$48.8 million the following year.

Campbell was frank in her assessment of the possible political implications of these cuts:

Our government and all previous governments have emphasized that veterans are special Canadians, fully deserving of the best their country can provide. The message must now be that, while this is true, veterans have to make a contribution to deficit reduction, and that is to be achieved through benefit reductions, a 29% increase in accommodation and meal rates, and by vigorous scrutiny of eligibility. The measures may lead us to an emotional fight. You may recall that the cut to VIP in 1990 was the lead media Budget issue for several months.... We start with two strikes against us:

- i) war veterans are hugely popular with Canadians and their political support is highly coveted; and
- ii) we are picking the pockets (and that is the effect of many of the measures I’ve proposed) of elderly people who are poor or disabled or both. The media image could not be worse....

While the government was successful in 1990 in gaining the neutrality and limited support of the veterans organizations’ leaders, they were simply unable to control their members. There is no practical possibility of gaining their support on this occasion....I can only conclude that we are in for a far rougher ride.

The Legion's response to the announced cutbacks indicated she was right. 'No longer can one expect understanding and compassion,' its magazine argued in a lead editorial. 'The rules will be stringently applied and even VAC employees may come to be seen as a bunch of hard-hearts...Clearly, Canada's veterans services are at risk.' Campbell also anticipated similar problems with Veterans Affairs staff. There was an 'absolute requirement,' she argued, 'that we reverse the existing culture of generosity which permeates the thirty-two VAC district offices, and replace it with an attitude and approach that reflects today's fiscal realities.' This too would be a tough sell. As other department officials pointed out, over the past decade the continuous expansion of the program (from 5000 clients and \$6 million in expenditures in 1984/85 to over 85,000 clients and \$175 million in expenditures in 1992/93) had 'fundamentally oriented VIP delivery staff toward program growth ...District staff equate VIP growth to job security.' The proposed cuts represented 'a significant...shift which contradicts the ongoing VAC operating philosophy.' Since field staff would 'bear the brunt of criticism from veterans affected...altering the field philosophy from generosity to strict application of the law will be difficult.' This indeed proved to be the case. 'It was a hard pill to swallow because it was a complete change-about. A lot of people had a difficult time adjusting,' Jacques Boisvert recalled.

Not that they didn't understand that there had to be some cutting at about that time. We were all taxpayers as well as government workers. We all understand that part of it, but if you are really impassioned about the kind of work that you do and the client that you serve - and Veterans Affairs has always been in my view

one of the most passionate about benefit delivery to clients - what is difficult to sell is how you can cut back funding for these people that not many years before or not many months before you have been promoting...[as] so deserving. And now you are going to slash and burn. It was very difficult.

Of all the proposed cuts, none was more politically sensitive than trying to restore a clear link between the pensioned condition and eligibility for the VIP for disabled veterans. By 1993 more than one-third of the entire VIP caseload, or 32,000 clients were 'CPC-only' veterans who accounted for \$58,000,000 or a third of the program's overall budget. More than two-thirds of this group (68 per cent) were pensioned at between 5 and 32 per cent disability 'with most being on the lower end.' Although pensioners were the first clients of the AVP, they were eventually expected to comprise only a small proportion of the program's overall caseload once low-income WVA and CSO veterans, with much higher needs, ultimately came on stream. Instead, pensioner access to the VIP exploded rapidly in the mid to late 1980s as a result of vigorous promotion of the program by district counselors and regional offices, widespread publicity by veterans organizations such as the War Amps and Canadian Legion, and growing ambiguity over how closely their right to receive VIP had to be linked to a war-related pensioned condition. When Veterans Affairs 'culture of generosity' reached its peak in 1988 during the George Hees era, counselors in some regions were assigned 'what amounted to quotas to fulfill in terms of increasing their client caseload,' officials recalled. 'This type of pressure to create numbers greatly influenced the way that decisions were made in the field.' As another senior official noted, resource allocation in the department 'was based on the number of

VIP clients [a] region had. So for every 350 VIP clients they had an area counselor. And for every five area counselors, they had a chief and for every chief or two there's a [District Director]. So if you're a manager and you're looking for resources, that's the way to get resources. It wasn't based on client needs and it wasn't based on work, really. It was based on the number of VIP clients.' Disability pensioners became the 'most readily available source of potential VIP recipients,' department staff argued, 'because their eligibility to VIP was based on a judgement call.' How closely could their need for services be related to a war-related pensioned condition?

Changes to the wording of Veterans Treatment Regulations in the 1980s widened the scope for interpreting this linkage, giving district and regional staff discretion to allow access to the VIP for pensioners 'when the sum of [their] disabilities, including pensionable disabilities' created the need for VIP services. In some regions the pensioned condition continued to be viewed as the 'significant factor.' In others, however, it was only 'one element of the overall disabling condition(s) of the veteran necessitating the VIP service.' In the absence of clear national guidelines for interpreting the linkage between pensioner eligibility and war-related disabilities, regions were free to go their own way. Hearing loss or flat feet, for example, could be used to establish VIP eligibility for housekeeping or groundskeeping even though it was not clear why these particular war-related disabilities restricted a veteran's ability to perform such tasks. Similarly arthritis, respiratory or heart problems, when not traceable to the war, might or might not be used in combination with other war-related disabilities as grounds to argue for access to the full range of VIP services. Much depended upon the subjective judgment of regional officials and district medical officers. 'You had a constant conflict,' Duncan Conrad of Veterans

Affairs headquarters recalled,

between the counselor...trying to address the need of the client, and the pension condition which was set out by the pension people. The problem was more in terms of our desire - 'our' meaning the minister's desire - to try and address needs, and not in terms of the pension condition in terms of doing what they needed to do. Our idea was 'let's get to the need, and let's find a way that we can link the health problem to the pension process.' And that's why we actually ended up expanding the program to less and less link to the pension process.

Or as a 1991 internal department study put it, 'as veterans age and present ever more complex combinations of health problems, it will become increasingly difficult to say with any certainty whether or not the need for a VIP service is required because of the pensioned condition.'

The War Amps and Canadian Legion also added their voices to the pressure for liberalization by arguing that 'all CPC veteran recipients [should] automatically qualify for VIP' A final incentive driving program expansion was pensioners' realization that the VIP 'was a window to access comprehensive treatment benefits.' By 1993 Veterans Affairs officials estimated that "as many as 10,000 pensioners could have 'dormant' VIP accounts (i.e. they access \$0 and \$1 VIP contribution arrangements solely to 'gate' into treatment benefits." Cutting these clients off would not save much money within the VIP budget. However, it would run the risk of provoking a firestorm of anger which would make the 1990 media spotlight on the cancellation of heavy housekeeping pale in comparison.

Further discussions within the Field Advisory Committee and a sampling of regional case files, also drove home the realization that attempting to strictly relate benefits to the pensioned condition for all the war-disabled within the program would result in at least 20 per cent of pensioners in the Atlantic region and up to 40 per cent of pensioners in Quebec losing the VIP. The implications of such an action would be ‘devastating,’ officials realized, since

a large number...will lose not only their VIP services but also their access to treatment benefits for other than their pensioned conditions. At the same time, districts and regions will be inundated with complaints from disabled pensioners....The Department will be seen as abandoning the most disabled of veterans at a time in their lives when they require the most support. This has the potential of a reaction well beyond the heavy housekeeping issue.

Since Veterans Affairs had also been cutting back on the employment of doctors and nurses at the district and regional level ‘at a time when clients are growing older and their needs are more health-related,’ it was also not clear where the medical personnel required to weed out the ineligible pensioners would be found or even if they would cooperate in the exercise, particularly in the case of pensioners with highly debilitating conditions such as stroke, alzheimers, schizophrenia or alcoholism. As a result, the FAC recommended that a return to a stricter definition of pensioner eligibility for VIP, clearly related to their pensioned condition, should be applied only to new applicants. Pensioners already in receipt of VIP would have their eligibility for the program ‘grandparented.’

Pending final approval, this 'interim' policy was announced at the end of June 1993, and it would stay in place throughout the remainder of the decade. In hindsight, Darragh Mogan observed that the department's insistence on trying to relate the need for VIP care to a veterans war-related injuries was 'absurd. To be blunt with you, the requirement, although legal, to relate long-term care for an 80 year old to something that happened 60 years before, unless it was extremely severe, was an absurd position to put relatively lower paid employees in by the executives of the department who were higher paid...And we've come to grips with it now. We are increasingly coming to grips with it. But it's that entitlement basis again...which comes to the fore. But in terms of public policy, it's absurd. Simple as that.'

The most important consensus reached through the creation of the FAC, however, was an agreement to call a halt to the process of ascertainment, or trying to recruit new clients. "What really came out of there was 'let's stay clear on our philosophy, let's stop ascertaining. We're getting two messages, we're getting messages for our managers to go out and find VIP clients and then you're telling us now that we have to save money,'" Judy Lougheed recalled.

So there was a relief in a way that, well, great, finally we're going to make some sense....Out of that meeting we came up with recommendations and the agreement was made to move in that direction. So we had saved 10 per cent of VIP before we changed one policy. Word got out. And got back to me very quickly, that 'yeah, guys, you're using your heads, we're not going to ascertain any more....We changed. It was amazing...Because when...you get down to [trying to enforce]

the same dollar, how much an hour, it's pretty hard to do in a country this size.

But when you tell people to use what's reasonable for your district, to start using [a] needs-based [approach]... That was an interesting experience.

By early June 1993, either as a result of these efforts, or due to the culmination of demographic trends, or both, it was already clear to senior officials within the program that the VIP had reached a major turning point. Its caseload was dropping for the first time in the program's history. Instead of being faced with a daunting revenue shortfall, based on inaccurate forecasts of program growth, the department would actually underspend its approved budget reference levels without the need for further fiscal restraint. As a result, Darragh Mogan advised both his ADM and field staff to 'move cautiously' and slow down 'the pace of implementation of cost containment measures.' The crisis had passed, in the end, without the need for major retrenchment or the anticipated storm of protest from veterans' organizations. As a result, a new program philosophy of tighter fiscal control was introduced but, as a subsequent report argued, there was 'little monitoring of results.' Kim Campbell and the Conservatives went on to suffer a devastating defeat in the October 1993 election. For the remainder of the 1990s, under the new Chrétien Liberal government, Veterans Affairs would emerge mostly unscathed from Ottawa's ongoing fiscal restraint and program review exercises. As former deputy minister Dave Nicholson recalled:

We escaped all that. We defended, we just put the fences up here. We played veterans, you know, you don't do that to veterans. We played the game. I took

that so seriously you wouldn't believe it...And I never left a nickel on the table. There was nothing there. I mean, what do you want me to take away?...You can't take pensions away. You are going to take the VIP from the VIP recipients? But during that period of fiscal restraint there wasn't much opportunity to make any expansion of programs... I don't know of any elements that were added.

Within five years senior officials in the department would be asking whether there needed to be any criteria for linking the VIP to a pensioned condition. 'Today...very few cases actually end up having to link themselves,' Duncan Conrad observes, "or even if they do, we broadened the interpretation of the policy to the point where people use terms like 'severely disabled clients' and things like that, to actually get people eligibility into the program."

NOTES

Chapter 6

FROM ENTITLEMENT TO NEED: TRANSFORMING THE VIP, 1994-2003

Over the next ten years the deepening old age and declining health of the Second World War veteran cohort and their caregivers dominated the VIP policy agenda as the average age of the program's clients reached 77 by 1995 and 82 by the century's end. From a peak of 87,975 in 1993 the VIP caseload dropped to 69,706 by the year 2000, a reduction of 20.7 per cent. Program costs, however, only shrunk by \$6 million or 2.7 per cent, mainly as a result of the intensified health care needs of the veteran population. The consequences of an aging and frailer VIP caseload had served as a subtext to the most contentious policy debates the program faced during the early 1990s. It helped to explain the vehemence of the War Amps' reaction to the cancellation of heavy housekeeping. It partially informed the move towards advance pay as a means of eliminating the voluminous receipts veterans needed to submit for reimbursement. It also explained the resistance of many field staff and officials within Veterans Affairs headquarters to restoring a stricter linkage between the need for VIP services and a war-related pensioned condition.

A further sign of coming to terms with the needs of an aging clientele emerged between 1991 and 1994 when senior officials at Veterans Affairs headquarters embraced a pioneering program on 'Care for the Caregivers' being developed by the new Nova Scotia Centre on Aging at Mount Saint Vincent University in Halifax. Researchers at MSVU were innovators within Canada in developing training programs to support the needs of informal caregivers as a means of avoiding caregiver burnout, a theme which was growing in importance within the ranks of Canadian gerontology and social work during the later

half of the 1980s and early 1990s. In 1989 Dr. Mary O'Brien and her colleagues at MSVU won a three year \$250,000 grant from Health and Welfare Canada's Seniors Independence Program, to provide informal caregivers with the information, training, and emotional support they required to do their work more effectively, through a project they titled 'Care for the Caregivers.'

For Duncan Conrad, Director of Policy and Program Development for Veterans Affairs, the needs of spousal caregivers within the VIP had long been 'one of my passions.' As he recalled,

It goes really back to the very root of the program...[E]ven in the early stages when we were doing assessments there was always a recognition that beside every good veteran was a good spouse that was providing some sort of support....Whenever a counselor went into a veteran's home, the interview was always with the veteran and the spouse, generally a woman in most cases who was the caregiver...So as the program evolved it started the recognition of the fact of the role that those individuals played...If that person wasn't there, the department would end up having to spend a whole lot more money and a whole lot more energy and/or institutionalize the client as a result of the services that weren't being provided by these people.

When an article about the MSVU 'Care for the Caregiver' project caught Conrad's eye in March 1990, he told his staff he was 'interested in learning more about the program.' 'We must think about how care giving issues can be built into our current VIP

program' since informal caregivers were 'critical for keeping veteran clients at home.'

With the department facing a 'future of increasing clientele and steady or declining resources to address increasing need,' any strategies which could fortify informal care were essential in order 'to meet the care needs of the client population.'

The following year Conrad got his chance to learn more about the MSVU project by attending a two day 'Care for the Caregivers Conference' it was hosting in Halifax. He returned to Charlottetown enthused about what he had heard, particularly around the need for greater focus on respite, support, and education for caregivers, all of which had 'relevance to our situation.' Veterans Affairs had to discover more about the 'needs of our caregivers,' the 'gaps that exist' and the ways in which the department could 'link our policy on respite care to caregivers' needs.' Conrad asked all regional directors to send him data on the resources available to caregivers in their district as well as the extent to which caregiver needs were being assessed. They were also asked to identify the greatest gaps in caregivers' programs in their region as well as the role Veteran Affairs could play in meeting these needs. Judy Lougheed, program development coordinator for the department, was then asked to assemble the information being received into a policy memorandum on 'Care for the Caregiver.'

In her report, drafted and revised between January and August of 1992, Lougheed argued that although the department had talked a lot about caregiver needs over the past few years, particularly in relation to the VIP, so far it had done 'little...to formalize a program that recognizes and supports the caregiver,' even though the recent Price Waterhouse study of 300 sample VIP case files revealed that 'at least one third of the veterans could not be left alone.' In reviewing the regional directors' response to Conrad's

call for information on caregiver needs, Lougheed singled out five key gaps: client assessment, respite care, educational support, emotional support, and financial need. Most districts, for example, reported that ‘assessing the needs of the caregiver is not a part of the case management process’ and claimed that ‘our major if not our only concern is the veteran.’ Instead, Lougheed argued, ‘a family-centred approach should be the focus...[D]epartmental assessment tools should be revised to reflect this change.’ Otherwise, Veterans Affairs would continue to have ‘very little data on the actual needs of our caregivers.’

Respite care was provided through some department programs but there were significant gaps. Veteran caregivers providing support to their spouses, for example, were not eligible for respite care. Pensioners receiving attendance allowance could use it to provide respite care, but only if their counselors agreed that ‘respite for the caregiver [was] a benefit to the client’ since he was the one entitled to the allowance. In 1987, respite care was added to the veterans treatment regulations, but it was limited to only one month a year and was targeted more at dealing with the consequences rather than the prevention of caregiver burnout. Finally, the availability of respite providers varied widely across the country and Veterans Affairs had ‘not for the most part been proactive in encouraging the development of new programs.’ On the question of educational or emotional support for caregivers, the department had developed no strategies whatsoever beyond the ongoing informal advice and encouragement provided through district counselors or nurses. If the department was serious about its commitment to keeping veterans in their homes as long as possible, Lougheed concluded, ‘energy and resources must be applied in support of the caregivers of those veterans. Provision must be made to

meet assessed needs not only of the veteran but of the caregiver. Support should include educational, emotional, and financial components as well as appropriate respite.’ These recommendations were ‘not...high cost items’ but they did represent a ‘philosophical change in the concept of caregiving.’

In the summer of 1992, as a result of Loughheed’s report, the department’s Health Care Policy Review Committee recommended approval of a pilot project ‘designed to identify caregiver needs and to identify successful strategic responses to assist in meeting these needs’ with the ultimate goal of allowing Veterans Affairs to develop a ‘purposeful caregiver support program, within the parameters of VIP, for nationwide implementation’ and to identify the ‘resources that would be required to implement such a program.’ As a first step in this process, Duncan Conrad negotiated an agreement with Dr. Mary O’Brien, director of the Nova Scotia Centre on Aging, for the MSVU ‘Care for the Caregiver’ team to deliver an educational and training program on caregiver support for both VIP staff and selected caregivers, as a pilot project at two Veterans Affairs regional sites, Edmonton and Ottawa, using training manuals, films, and workshop techniques adapted from their successful three year MSVU project. For department staff the training would focus upon teaching methods for handling caregiver problems, particularly in managing stress and avoiding client burnout. For VIP caregivers it would concentrate on providing emotional support and education in the resources and strategies for successful informal care. “Many of our veterans now fall into [the] category of the ‘frail elderly’ population,” members of the project team argued. ‘Much of [their] support is provided by Veteran’s families, either the spouse who is herself aging and facing the lack of physical and emotional strength, or an adult child in her or his 50s or 60s and even 70s.’ Most of them

had 'very little experience in the area of caregiving to the elderly.' They might also 'be facing their own problems with the aging process and may not have the energy to provide needed care.' In addition, they were often 'overwhelmed by feelings of guilt, anger, failure, and confusion resulting from the demands of caregiving,' leading to situations of burn-out or elder abuse. 'These caregivers of veterans need increased support systems in order to effectively continue their roles as caregivers.'

The pilot project ran in both Edmonton and Ottawa between May and June 1993, under the direction of Marlene MacLellan, a faculty member and project leader at MSVU. It was widely viewed as a success, although more for the caregivers than for Veterans Affairs staff members who participated. In all 34 elderly caregivers (80 per cent females and 20 per cent males), ranging in age from 56 to 82 years took part. Many were considered to be at high risk of physical, mental and emotional exhaustion. They participated in a weekly series of six two and a half hour workshops dealing with topics such as the aging process, stress management, growing dependency in the person they cared for, communication skills, and perhaps most importantly, how to look after themselves, deal with their own feelings, and avoid burn-out. They also were given practical information on respite and caregiving resources available in their region. A key goal of the project was to develop strategies of mutual aid and support and to 'encourage its development among the caregivers.'

As the sessions unfolded the participants reaffirmed their high degree of satisfaction with the VIP. Indeed the most commonly identified key contribution to caregiver support was assistance with housekeeping and groundskeeping, services they were already receiving through the program. As the pilot project's final report concluded

‘services from the Veterans Independence Program (housekeeping, groundskeeping, personal care) greatly assist the caregiver in preventing caregiver burnout. Without it, the veteran and/or his/her spouse would be in a long-term care institution and this would result in a major cost to the health care system.’ Nonetheless, the number one unmet need identified by the participants was for a more frequent and wider range of respite care, ‘both in the home, and out of the home, including day care and institution.’ Indeed, almost 40 per cent of the participants reported receiving no respite care whatsoever.

The most common refrain of those who took part in the workshops was the emotional and therapeutic benefits of discovering ‘they were not alone’ in their feelings of guilt, anger, anxiety, frustration, and depression. ‘There were so many people in the same position I was in...I was surprised that they mentioned the same things that would go through my mind...Sharing our similar problems really helped.’ Participants also reported how crucial it was to think about the ‘different ways the caregiver can better take care of themselves so that they can take care of the person that is ill’ as well as ‘where to go for help if you need it.’ They also underscored the importance of the ‘affirmation that together we were doing our best.’ Others noted they learned ‘to have a little bit more feeling for how he is. I find that I look more at his side of situation now and that helps me [become] maybe a little more compassionate,’ or that ‘I learned how to relax and not let things bother me...I realize I can’t do everything in one day.’ As one participant summed up her experience within the group, ‘I think it was about the first time in a month that I had laughed and felt relaxed. I found that awfully good medicine. It was such a good group...There was a lady there who already had her husband in the Rideau Vets Home, so it made me feel like I wasn’t jumping the gun by taking that step. All around it was a

wonderful workshop and if DVA can possibly keep it up, I can't see anybody not enjoying it.'

The project's key recommendations were that Veterans Affairs continue to develop educational and support sessions on caregiver support for clients and caregivers within the VIP; that it support further research and initiatives on assisting caregivers; that it provide training to staff based on the needs identified in these areas; and that VIP clients be made aware of all forms of community support and assistance for caregivers. The final report also argued that given the low cost of these initiatives, they made good fiscal sense.

In times of decreasing health care dollars, communities will be forced to rely more and more on the informal care system as a source of long-term care for the growing number of the frail elderly. The complexities of disabilities together with diminishing health resources from the provincial and community sector makes the informal care network worthy of development. The informal caregiver will more and more be viewed as a resource to maintain and/or increase the level of care provided to the frail elderly in their home.

However, the stress on 'cost containment' proved to be somewhat of a double-edged sword as it was also used as an argument against expanding the department's commitment to developing a 'purposeful caregiver support program, within the parameters of VIP, for nationwide implementation' as suggested by Judy Lougheed's original 1992 policy memorandum on the topic. The very years when the 'Care for the Caregiver Pilot Project' was in process were also the time when fiscal restraint pressures

within both Veterans Affairs and the federal government reached their peak. As result, senior officials within the department continued to fret about the possibility that caregiver support programs might become another form of policy creep. “I still feel this is a ‘slippery slope’ and should be approached with caution,” deputy minister Nancy Hughes Anthony warned when the ‘potential expansion costs’ of the ‘Care for the Caregiver Pilot Project’ were brought to her attention. Darragh Mogan, who supported the initiative, nonetheless advised his health care directors that senior officials had voiced ‘understandable concern about the momentum growing for such an initiative being too large for us to deliver on.’ When told by his staff that there was an ‘overwhelming response from the caregivers to participate in this project,’ Mogan replied, ‘The question is cost...Is this initiative an effective form of cost containment?...Officials at Treasury Board would be open to new initiatives which in effect, demonstrate ways to contain costs.’

For the time being, Veterans Affairs decided to hedge its bet. A few more pilot projects would be approved in 1994 to provide a ‘better indication of the likely growth in interest...as well as the potential program cost to the Department and [the] requirement for human resources.’ However, the nationwide implementation of a Care for the Caregiver program within VIP, originally called for in Judy Lougheed’s 1992 memorandum, never materialized. ‘It is not new programs that are required,’ assistant deputy minister Serge Rainville eventually concluded. ‘Caregivers want support in the form of recognition.’ The department would ‘share its expertise’ with provincial, municipal officials and voluntary associations in ‘developing caregiver support programs. These approaches to delivery would have minimal costs to the Department.’ But that was

as far as it would go for the time being.

Nonetheless, the 1992-94 'Care for the Caregiver' pilot project was an innovative and symbolically significant initiative by Veterans Affairs in the context of a difficult fiscal environment. By giving a high profile to the issues of caregiver burnout, caregiver support, and caregiver recognition the department was one of the first government agencies in Canada to publicize and support research on an issue which would explode in importance during the decade ahead. By making the training manuals and video tapes of the project available to organizations across Canada and around the world, Veterans Affairs also helped to get the message out about the highly gendered costs and consequences of informal care for the elderly. As Marlene McClellan, director of the Care for the Caregiver pilot project recalled:

Veterans Affairs at the time, because of their population, was beginning to realize that caregiving was emerging as a serious issue. I think they were really at the forefront of that. This was post the operation of the VIP program so they were learning from that program. They were seeing situations in the home where the spouse, typically a wife caring for a husband, they were seeing that caregiving piece emerge. And I think that was a very progressive observation ...because they had the experience and the data from their VIP program.

These insights into the needs of caregivers would not be lost within the department as it moved towards a far-reaching transformation of the way it delivered all of its services to clients during the second half of the 1990s.

Until 1993 the major challenge facing the VIP was explosive growth. How could Veterans Affairs find ways of servicing the needs of a ballooning VIP caseload during an era of fiscal restraint in which requests for additional staff fell on deaf ears? Despite the formidable administrative challenges this problem posed, by the mid 1990s the department had still not been successful in devising management strategies to measure or standardize workloads, to develop national consistency in assessing or responding to the needs of its clients, or to devise mechanisms for efficiently reallocating its most important asset, the time and skills of its counselors. The inability to resolve these problems, exacerbated by the difficulties in implementing advance pay, created growing frustration at departmental headquarters in Charlottetown as well as within district and regional offices across the country. As a 1991 evaluation of the VIP put it, ‘when a delivery environment is such that a fixed number of resources are expected to assume responsibility for an increasing number of clients, something is eventually bound to give.’ Within district offices it was the loss of staff morale. Case management goals for counselors were viewed as unclear, training was characterized as inconsistent, and administrative procedures were described as ‘over-controlled and inflexible’ creating a work environment of ‘justification and control’ rather than ‘judgment and trust.’ As a result, staff delivering the program, the evaluators argued, ‘feel that they are being confronted by a series of demanding management initiatives which draw VIP effort away from the client towards quantitatively-oriented administrative activities.’ Although a widespread complaint was the unevenness of caseloads both within districts and across regions as well as the stress on ‘quantitatively oriented administrative activities,’ there was actually little useful data to measure how counselors performed their work or how it might be reallocated more

effectively. Nonetheless, it was abundantly clear that as the VIP caseload moved deeper into old age, the demands placed upon counselors were only going to intensify as the risks to their clients grew. A key recommendation emerging out of the 1991 program evaluation, therefore, was the need for developing a 'resource allocation model for the VIP which will take into consideration the workload implications of differences in VIP cases.'

Five years later it seemed that little had been done. Another even more comprehensive review of the VIP, undertaken between 1994 and 1996, concluded that 'lack of standardization is one reason why it is not possible to determine if VIP is getting the best value for its money.' An analysis of sample client files revealed 'no consistency in recording the type and level of services provided.' In one-quarter of the cases there was not enough information to determine if the services were appropriate. The department had also been unsuccessful in implementing a standardized national client assessment form. Regions were still using their own forms which varied widely in the quality and integration of the information provided. As a result, the evaluators found 'poor documentation' and little evidence of case management. 'Much of the information and assessment of the client was directed primarily to justify VIP services' rather than to interpret needs or to document the counseling activity that actually took place. Obligatory reviews and reassessments were not being done. Some high risk cases received comprehensive care planning while others got no more attention than low risk clients. Since 70 per cent of VIP clients were receiving only low level services, it was not clear that case management in most instances was even required 'yet the expectation existed.' As Judy Loughheed recalls, 'VIP required all this labour intensive stuff [like the yearly determination of need visit] that

was really doing nothing, and our clients were getting sicker and more frail. Some of them needed several visits, a lot of them needed none. ...And what was happening was the district director, in order to make sure they met the Act, gave a list to the area counselors of all the people who were due for their annual review. And that became their work.' The result, for counselors juggling caseloads as high as 450, was 'a great deal of staff pressure and frustration, and wasted time and resources.'

The key gap was client assessment and screening. 'The assessment process is the most critical to a successful home care program and also one of the most time consuming and costly aspects of VIP program delivery.' Yet in 1996 the VIP still lacked a nationally consistent and reliable tool for doing it, which could determine who among a counselor's caseload needed only partial assessments through office visits or telephone inquiries, and who required the full assessment provided through a home visit. During the earlier years of the VIP, when most clients were in their 60s and their needs, as well as those of their spouses, were less intense this deficiency was not as crucial. Now that the average age of VIP clientele had passed 75, it could no longer be ignored if counselor workloads were to be managed effectively and their clients protected. District offices needed a standardized screening process which could make these distinctions. And this in turn required a reliable assessment of risk. 'To date this has not materialized,' the 1995 evaluation report argued.

Some counselors are determining the level of risk before VIP interventions are in place while others do so afterward; others are classifying risk in terms of workload. [There are] large inconsistencies both between and within regions. Since risk data is incomplete and unreliable it is only meaningful to the individual

counselor who may use it to prioritize their caseload....The term 'risk' is not useful as there is no understanding of what the definition should be.

Lacking a common standard for assessing client risk or screening the level of required interventions, Veterans Affairs had no reliable information for undertaking quality control or measuring and efficiently allocating workload within the VIP. 'Previous resource allocation studies did not provide sufficient information for management to take action as they measured caseload, not workload.' But caseload size, in the absence of a consistent measurement of client need and therefore counselor activity, was a rough instrument for assigning resources, which not surprisingly had 'remained virtually unchanged [between regions] for the past five years with no assurance that the allocation is appropriate.' The report concluded that 'the department has not determined the optimal counselor workload or the optimal number of staff required to support and supervise the counseling function at the district level....It is difficult to determine the appropriate VIP staff resources required without knowledge of the true rate of client utilization of the program.' Here was where the unresolved issues of client assessment, risk screening, workload and staff allocation converged.

Both Veterans Affairs headquarters and district offices had been aware of these problems for some time. Indeed most of the insights contained in the 1996 audit and evaluation had been gleaned from program staff and had been the subject of extensive discussions within the Field Advisory Committee and the VIP Improvements Project throughout the early 1990s. In 1991, for example, as part of the VIP Improvements Project, an attempt was made to formulate a single risk screening instrument and risk

guide for use in all regions so that ‘the right client is provided with the right service at the right time.’ Reflecting the growing movement in social work practice throughout the early 1990s for a new philosophy of client-centred service delivery, project officials argued that case management within VIP should be ‘client-centred so needs can be assessed, services/interventions coordinated and effectiveness monitored for follow-up activity.’ A sub-committee was formed to develop a standard risk assessment tool by the end of 1991 to be used across Canada but with the ensuing turmoil over the implementation over advance pay in 1992 for the time being nothing came of the initiative.

Within the district office for North Bay, Ontario, the chief of client services decided to take matters into his own hands. Frustrated by shrinking budgets, expanding client demands, and counselors complaining of unmanageable caseloads, Carlos Lourenso, near the end of 1992, developed his own in-house tool for prioritizing work. ‘Raw client numbers had no real meaning,’ he realized, which made it ‘difficult to measure and allocate resources realistically according to real client need.’ Lourenso’s goal was to design a ‘quality case management system that encompassed Veterans and their dependents, which was assessable and measurable, and consistent with the VAC mission statement.’ After eight months of research scouring the international literature and extensive consultations with professionals, community agencies, and faculty at Nipissing University, Lourenso and his staff devised a Risk Contact System for managing caseloads. Using the department’s data base software they created their own program for coding information on each client’s health and financial status, personal and community support and coping abilities.

Every client was assessed and a code (1 - good, 2- fair, 3 - poor) was assigned for each element and the client's level of coping skills was identified based on standards acceptable to Social Service Practitioners. This coding result[ed] in a final Risk Contact Code which enable[d] the Case Manager to assess the amount of time it takes to manage each client and the time to manage a caseload. The system [was] also self-validating as estimated time [could] later be compared to real time, thus enabling adjustment and fine-tuning as required. This information, when calculated in conjunction with other measurable activities such as travel, training, etc. allow[ed] our Area Counselors and Management to accurately and effectively measure caseloads in terms of real numbers and time.

The system also allowed for building in support from other professionals such as nurses. The result was software which provided counselors and managers, for the first time, with 'a snap-shot view of any particular caseload, or of the entire [district office] caseload' so that, for example, they could determine 'how many VIP clients, living in rural locations within an area...have poor personal and social supports.' It also allowed the North Bay/Thunder Bay office to 'realign areas, identify gaps and fragmented services, standardize caseloads, and identify clients based on their level of risk, on their level of coping, and document departmental contacts and interventions.' Implemented in November of 1993, Lourenso's innovation was such a success that by June 1994 it had been picked up and installed within every district office in the Ontario region 'as a means of equalizing workloads within districts and as a determining factor in allocating resources between districts to meet changing counselor caseload requirements.'

Given the lack of progress at the national level on developing a common standard of client assessment and risk screening within the VIP, Lourenso's Risk Contact System caught the attention of senior officials at Veterans Affairs headquarters as a timely solution to a longstanding problem. Judy Lougheed, recently given the job of revitalizing the VIP's health service directorate in Charlottetown, was asked to 'take on the validation of the system' and if the results were positive 'develop an agreement for national implementation.' Lougheed had played a key role in the creation of the department's Field Advisory Committee to solicit grassroots input into department policy-making from district and regional staff. She had also advocated for greater attention to caregiver needs within the VIP. As a former community health nurse within PEI's homecare sector, she came to Veterans Affairs in 1992 with a strong belief in the importance of community-based and client-centred approaches to assessing need. Working to develop a national needs-assessment strategy for the VIP was a mission she instinctively liked.

One of the big goals for [our] unit was to look at the VIP program from several different points of view but mainly from the service point of view...The difference...between programs and services within this department are that programs are things that are legislated that we pay money for so that someone can get their dentistry paid for, their drugs paid for. The services side are what we do, our staff do, for the veterans. An assessment... should not be done just to attach people to a program but rather to determine need....[Our] unit took on the responsibility of changing or trying to change the mindset within the department.... [to say] let's look at a needs-based client-centred approach where we start with a

really good assessment and work with the client to determine what the major needs are and *then* VIP becomes one way to help us meet that need. But there are other ways. We don't need to give people stuff they don't need...So [our goal] was to change that concept, [towards] an approach...that we value the actual service and what the staff do and not just what money the client gets at the other end.

Better tools for assessing client needs and risks were a crucial step in this direction. In order to determine if Lourenso's Risk Contact System could assist in developing a reliable client assessment instrument for the entire VIP Joe Bornstein, an external consultant with extensive experience in devising screening tools within the social services field, was hired in 1994 to work with Lourenso in order to assess the model's feasibility for implementation nationwide. After first confirming the consistency of the RCS model, Bornstein next provided all Ontario counselors with time sheets and asked them to record their daily interactions with low, moderate and high risk clients over a four week period early in 1995. In itself this was a significant piece of research because it represented the first time in Veterans Affairs history that the department was given 'a true and accurate representation of how counselors are spending their time on key tasks.' The results were startling. Bornstein's field test revealed that there was 'very little difference' in the amount of time Ontario counselors actually spent dealing with low and high risk clients. Gaps of seven to twelve minutes in care planning or follow up and evaluation between these two types of clientele with quite different degrees of risk were too small 'to have practical value in adjusting individual counselor workload' through use of the RCS. Implementing the system nationwide would 'simply perpetuate the status quo.' The larger

question raised by Bornstein research, however, was far more important. 'Is this what the department wants counselors to be doing?' he asked. Why *were* they spending almost the same amount of time with low and high risk VIP clients? Bornstein urged that Veterans Affairs should first 'consider developing new standards of practice' before it decided to implement any tool for measuring workload or screening risk, a point Lougheed echoed strongly in her comments to the branch executive committee of Veterans Services when she sent them his report. Put simply, the department first had to decide how it wanted counselors to spend their time before trying to measure it.

Branch Executive Committee members agreed that Bornstein's research on the work practices of Ontario counselors underscored the urgency for developing a national model for client service delivery. In June 1995 Lougheed's Health Services Directorate was put in charge of a new Veterans Affairs Service Delivery Project whose task was to develop such a model by April 1996. Its terms of reference outlined a formidable challenge. The department's clients were now 'reducing in number [but]...their needs are increasing,' even though there were 'no additional dollars for human resources or programs.' Any recommendations for changes in service delivery therefore had to be 'cost neutral.' They also had to address 'all VAC programs/benefits delivered at the district office level,' not just the VIP.

In late June 1995, the Veterans Affairs Service Delivery Project working group, which included broad representation of staff from district and regional offices, held its first meeting in Halifax. Over three days of discussion, chaired by Lougheed, the project team debated the principles of a core philosophical shift in the way the department went about doing its business. At the heart of Veterans Affairs, a synopsis of the discussion argued,

lay a tension between programs and services. Service delivery was about ‘providing individual clients with a level or intensity of service appropriate to their own particular problems/needs.’ Program delivery was about ensuring that ‘disbursements are made in accordance with program legislation, regulations, and departmental policy and procedures.’ The first was client-centred. The second was benefit or entitlement-driven. Veterans Affairs did both, but historically had been dominated by a program or benefit entitlement model. Veterans interacted with the department, for most part, through a complex series of pension, social, and health benefit programs, ‘each of which has its own program delivery structure that includes some form of application, adjudication, and payment process.’ The result all too often was an inflexible, overlapping, and confusing approach to meeting client needs. By 2000 the veteran population would “reach ‘very old age’ (80 years)” at which point the proportion deemed ‘at risk’ would rise from 20 per cent to 42 per cent. ‘[The] number of clients will decline but the risk of loss of independence will increase,’ Loughheed argued, as a result of deepening severity in health problems, dementia, widowhood, the declining health of spousal caregivers and greater prevalence of living alone. Veterans Affairs dominant program delivery model would not serve this population well. ‘When it comes to services, head office has to break down the program walls.’ The clear consensus of the meeting was that the department required a ‘client-centred service delivery model that is flexible and adaptable for purposes of responding quickly and effectively to client requests, problems, or needs.’

Adopting a client-centred service delivery model had other advantages. ‘A client needs approach...provides a very strong justification for maintenance of resource levels,’ Darragh Mogan pointed out. In a time of fiscal restraint and threatened cutbacks it would

‘recognize and legitimize the value and importance of the service activities that our staff are providing to clients, but which have not been recorded for workload measurement purposes unless the service has resulted in a VAC program benefit.’ Through this model, district offices would no longer be under the same pressure to recruit clients in order to justify staffing. A client-centred approach would also serve as the basis for the ‘eventual standardization of roles, responsibilities, and program delivery processes, [which] in turn...will allow the Department to ensure that clients, regardless of where they live or what programs they are entitled to, receive a consistent level of service from appropriate staff.’ Determining VIP eligibility in relation to the pensioned condition, for example, would no longer vary so dramatically across regions. Client-centred service delivery would also ‘provide senior management with a client-based rationale for future human resource planning and allocation.’ With no new resources for staffing, the department could only meet the higher intensity needs of high risk clients through ‘a change in staff roles and a reallocation of resources from throughout the VAC organization to areas of direct client service, based on placing resources where they are most needed.’ In other words, workload management practices through which counselors spent only ten minutes more time with high risk as compared to low risk veterans could no longer be accepted as standard practice. A final advantage of the client-centred service delivery model was its ability to harmonize closely with major changes already in process for the redesign and integration of benefit delivery by Veterans Affairs as a result of the new Client Service Delivery Network software currently in development.

In a follow-up meeting in Montreal in late August 1995 the Service Delivery Model project team worked to refine the CCSI process as well as a communications

strategy for disseminating it. Client-centred service promised to transform the way work was performed in Veterans Affairs district offices across Canada. From the outset, therefore, the project team recognized that getting staff to buy into the vision would be critical to its success. 'This is a time of ongoing change and review in government...Staff are uncertain about the future of the department, concerned about reductions and fearful of change. In order for them to focus on this project they must be convinced of its relevance to their future.' One strategy for winning their support was to emphasize how the service delivery model would 'empower staff to be proactive' by giving them 'more freedom to determine the intensity of care and amount of time allocated to individual clients,' particularly those with high risks. Additional training in gerontology would also give them more transferable skills 'for work within any future federal structure serving seniors.' However, it was also wise to anticipate 'some resistance...from staff who may be more comfortable with the program-driven approach to client service.' They needed to understand that 'without a plan to position ourselves to meet future needs of clients, the department is more vulnerable to downsizing measures.'

Some of the difficulties in winning staff support for the client-centred service delivery model became evident when attempts were made to field test it that autumn before a planned national implementation in the spring of 1996. Only the Ontario region, through its Brampton/Hamilton district office, expressed interest in providing a project test site. Plans for a pilot project in the Saint John New Brunswick district office fell through because 'counselors saw [it] as a potential threat to their job security.'

As fleshed out by the Service Delivery Model working group, with consultant Joe Bornstein's help, the model was 'really the elaboration, in detail, of the value shift in

service delivery throughout the social/health-service field. It involves an emphasis on the client as self-determining with respect to his or her own needs; a rationalization of resources, driven by client needs; and accountability for consistency in service delivery.’ To work effectively it required that a ‘client-centred approach [be] reflected in the operation of the whole organization.’ In operational terms the model meant the following fundamental changes in the way Veterans Affairs district offices worked:

- 1) all telephone contacts would result in contact with a real person.
- 2) All clients contacting the district office would be screened to determine the appropriate responses.
- 3) The screener would usually be a support staff person, not the area counselor.
- 4) The screener would provide information, refer the client to another agency, or to an area counselor if the screener judged that an assessment was required.
- 5) The counselor would decide whether to perform a ‘short’ or a ‘comprehensive’ assessment.
- 6) Short assessments were holistic and assessed physical, psychological, financial and social needs.
- 7) Comprehensive assessments were also holistic but included in-depth assessments of physical, psychological, financial and social needs.
- 8) The assessment process would determine the client’s degree of risk and develop an action plan. It might also include assessment by health professionals.
- 9) The counselor doing the assessment would work with the client to develop an

action plan.

- 10) The action plan would specify expected outcomes, the role of staff members and the client, and a monitoring schedule.
- 11) Targeted assistance would be provided through a client-centred focus.
- 12) Administrative processes, training, policies, standards and systems would support the client-centred service delivery model.

The key change in staff roles was a significant expansion in authority for the client service agent, who became the primary contact for veterans and provided the initial screening and targeted assistance as well as follow up and monitoring for clients who were deemed not at risk. The role of the area counselor was also transformed. The counselor would now be responsible for working exclusively with at-risk clients, for whom he or she would devise holistic, multi-dimensional, client-centred assessments, action plans, and provide psychosocial support and counseling. The counselor was also expected to act as a facilitator/enabler to assist clients to meet their self-defined needs.

Within months of field-testing the model in the Brampton/Hamilton district office, it was clear there were a number of problems. 'Many counselors, relieved of their administrative duties around VIP program delivery did not know what to do with their time. Case management concepts and practices were not common knowledge and the knowledge and skills necessary to deal with the complex problems of our elderly clients were not, in many cases, present,' the Service Delivery Model working group reported. Counselors also expressed a 'sense of loss over the redistribution of their low risk clients' or "became threatened, believing that their jobs were on the line. They saw 'work' being

taken away from them and could not see what was being added.” Client service agents, responsible for doing the risk screening were at first ‘overwhelmed with their new duties and voiced concern over their ability to take over the duties expected of them.’ Over the life of the pilot project, however, these staff became far more positive and came to feel ‘empowered by their new duties and the accompanying gain in knowledge and skills’ although they also expressed concern over ‘increasing workloads.’ A subsequent evaluation of the project, by Joe Bornstein and David Pedlar, highlighted the difficulties of implementing the CCSI model nationwide without sufficient lead time, consultation, and thorough preparation of staff.

The extent of change that was involved in the Hamilton-Brampton pilot cannot be overstated. During the pilot almost every work role in the office underwent transformation at the same time. Staff expressed anxiety and discontent with respect to the initiation and management of the change process. Staff felt criticized for the work they had been doing with clients in the past; that expectations for work within the new model were unclear; that they did not participate sufficiently in the change process; and there was insufficient communication at all levels of the office... [M]orale declined significantly in the early months of the pilot. In retrospect supervisors reported they had underestimated the magnitude of the change that was involved...Specifically, they were surprised that counselors were experiencing problems in making the role change.

Bornstein and Pedlar recommended that a two-year commitment was ‘not

unrealistic' in estimating the time required for putting the CCSI model in place. 'Staff input into the change process is essential for its success. All staff must have a sense of ownership in the outcome as well as be given the opportunity to work through their anxieties regarding change.' As a result of the Brampton-Hamilton Pilot Project, the goal of trying to implement CCSI nationally by early 1996 was dropped. Instead, the Service Delivery Model project team now argued that all regions should pilot the model 'before full implementation,' the deadline for which was now to be pushed back to 1997-98. 'The changes involve a lot more than simple streamlining, Darragh Mogan argued. '[They] involve...concepts which, for many, mean changing not only the way we do business but changing the way we think about our services to clients.' Further pilot projects testing the CCSI model were undertaken throughout 1996 and 1997 in Charlottetown, Halifax, Sydney, Calgary, and Vancouver, and more would be run in St. John's, Quebec City, Peterborough, Calgary and Victoria as development and field-testing of the CCSI model, as well as the complementary Client Service Delivery Network software required to facilitate its work, continued until the end of the decade. In October 1996 the department officially adopted CCSI as 'the broad-based theme inherent in all other department initiatives,' but it would not be until December 2000 before it was declared fully operational within Veterans Affairs offices across Canada.

Client-centred service is now the defining philosophy of Veterans Affairs and has facilitated the "transformation of the District Office...from an administrative body driven by cost-effective program management and 'gatekeeping' to a 'helping-agency' which is dedicated to developing close partnerships and working relationships with clients, various levels of government and the community." Judy Lougheed, who was instrumental in

helping to facilitate the change, describes the difference this way:

We started talking about screening. And not screening about eligibility ...[but] getting people thinking, 'okay, someone phones, someone comes in the door, what's the first thing you're going to do?' And the first thing they were going to do before was see if they were eligible for a pension or VIP.... But we're not doing that now. We're going to first of all ask why they're calling and inform them, 'look, we do a screening now, a screening process which really talks about needs'...Instead of answering the question, 'ok, we'll find out where your cheque is,' we start clueing in on this person...'Well, your cheque went out; you should have received it last week and if it isn't there we'll find out about your cheque. But now that we have you on the phone do you mind if we ask a few questions, and if we think so, do you mind if we have an area counselor visit the home?... And then we say, 'are you having any difficulties, have you been to the hospital, have you been sick in the last six months?' Just three or four questions and if they say yes, then we say, 'we would really like to refer this to your area counselor...and they'll give you a phone call and probably make a home visit....40 per cent of the client calls that come in require follow up that was not evident without further questioning, that wouldn't have been picked up...In order to change all this, we didn't have any more staff, so we had to change what work they did...So now the area counselors follow up the 20 per cent... that really have a lot of needs and do more visiting and more work with them, while the client service agents look after the people with the lower needs and do the annual reviews and...the screening

when people phone, and refer only those people who have identified needs that require area counselor follow up.

This focus on needs rather than eligibility, Darragh Mogan observed, represented the ‘most significant adjustment in corporate attitude VAC has undergone in 30 years.’ Although the implementation of CCSI has not been without problems, it has provided staff within Veterans Affairs with ‘a vision for the future’, which helped to ‘reduce fears of downsizing’ and reverse problems of low morale. For the purposes of this study the key significance of the CCSI is that its origins within the department can be clearly traced to the original service-oriented philosophy of the Veterans Independence Program and the desire of those working within it to develop better ways to identify and respond to the needs of a rapidly aging clientele. CCSI was simply the ‘next logical step in meeting the more diverse and complex needs of a very old client,’ a process which also sparked the search for a standard client screening instrument to assess veterans at risk and direct them to the resources they most needed. CCSI was ‘something that was not conceived by or directed from the senior levels of the organization,’ ADM Dennis Wallace pointed out. ‘[R]ather it originated at the service delivery level as a result of staff who [knew] the needs and wants of our clients better than anyone.’ In this sense client-centred service might be said to represent the permeation of the entire department by the philosophy and vision of the VIP, but with a difference. Again, as Lougheed argues:

VIP is one large big tool, but it is not, it shouldn’t be what’s driving our work, it should be the needs of the client. So from our perspective...VIP is seen as not *the*

program. VIP is some of the program eligibility that allows us to meet the client's need. It's just one program, there's institutional care, there's community care, it's wonderful to have that basket of services available, we're very, very fortunate. But it's the method of how you get there that's changed.

In the spring of 1999 the application of Veterans Affairs new client-centred service approach was put to the test through a creative solution for a longstanding problem: the existence of growing wait-lists for departmental long-term care beds, the same issue which in the 1970s had sparked the original creation of the VIP. Concern about wait lists for long-term care beds was a recurring concern within the department. As previously discussed a major internal study of long-term bed care needs for veterans between 1990 and 2020 estimated that demand would rise from 4500 beds in 1988 to 11,000 by 2001, the anticipated peak year. The problem was predicted to be 'especially acute for chronic care beds' whose need was expected to more than double to 4700 by the start of the new century. Between 1983 and 1987 the number of veterans on waiting lists for departmental beds across the country had risen from 330 to 821, a jump of almost 150 per cent. Veterans could expect a delay of more than a year to get into a departmental or contract bed and up to two or three years for access to a community facility, 'depending on the local situation,' the study argued. 'Providing an expanded home care program will not eliminate pressures for veterans' long-term care beds.' 'The expectations are 1) departmental and contract veterans beds will remain filled; 2) waiting lists will continue to grow at an increasing rate; 3) utilization of home care services will be extensive.' The need for more beds was 'critical.'

Despite the dire tone of this forecast, Veterans Affairs did not rush out to build more beds. Instead, co-payment fees for long-term care were increased to \$720 a month, type 1 adult residential care was eliminated for new VIP clients after 1991, and the numbers of veterans accessing home care through the VIP grew significantly. A new supply of priority access beds for veterans was negotiated with provincial governments and access to community care beds through the VIP was also expanded. By 2002, the predicted peak of the crisis, there were 3750 veterans living in 170 facilities where Veterans Affairs had priority access beds. Another 4500 were accessing beds through the VIP in over 1500 community care facilities and 550 resided at Ste. Anne's, the department's last remaining long-term care facility located in Montreal. This total of 8800 long-term care beds was 2200 less than the 11,000 forecast by the department's 1988 internal study. At an estimated average cost of \$50,000 annually per bed, this was a significant saving.

Nonetheless, between 1997 and 2002 waiting lists and predicted shortages of long care beds dominated discussions between the department, veterans organizations, and the Senate Subcommittee on Veterans Affairs. This time the debate was fueled by two concerns. The first was around the category of Overseas Service Veterans, (or OSVs) whose needs were almost completely unknown. These men, who numbered somewhere between 150,000 and 180,000, were described by veterans organizations testifying before the Senate Subcommittee as 'the phantom group' because they did not qualify for disability pensions, income-tested War Veterans Allowance, or the VIP and therefore had little contact with the department. Their single entitlement, by virtue of their overseas service during the war, was the right to a priority access bed. In his 1996 report on the

department the Auditor General drew attention to how little Veterans Affairs knew about the anticipated needs of the OSVs or the extent to which they might apply for a long-term care bed now that they had reached the age of 75 and were beginning to experience greater health risks. Veterans Affairs 'could face significant unplanned costs' from this group, he warned. Department officials were also concerned. 'In the next three to eight years they could approach the Department in increasing numbers. Forecasts of numbers of OSVs approaching the Department have not been made but a high rate of institutionalization is estimated to be 10% based upon the current institutionalization rate in Canada of 6-7%.' This could generate a demand for thousands more additional priority access beds, compared to the 4000 currently in use.

The second concern was waiting lists which had been rising throughout the 1990s, although not to the levels reported in 1987. In 1998, based on its own inquiries at 13 facilities across six provinces the Legion claimed that more than 500 'duly qualified veterans...are waiting for the health benefits they are entitled to and richly deserve.' The department's own figures revealed that in 1999 there were 368 veterans on waiting lists for priority access beds in Ottawa, Victoria, and Halifax alone with wait times of over one year. Across Canada, a year later, the number reached 677, rising to 814 in 2001. 'There are already long waiting lists for the available veterans priority beds,' the Senate subcommittee report Raising the Bar: Creating a New Standard in Veterans Health Care, argued in 1999. 'There is also a very real concern that a substantial percentage of the 160,000 overseas veterans entitled to a priority access bed will invoke this right.' At Senate Veterans Affairs sub-committee hearings in each year between 1997 and 2001 Cliff Chadderton, Chairman of the National Council of Veterans Associations, continued to

pound home this theme.

Five years ago we brought to your attention the issue of the phantom veteran. We know he exists, but we have no record of him. However, he served in World War II. He is back in Canada now. There is no doubt that if he continues to live he will require a long-term care bed... We do not really know how many there are... We told this committee four years ago that there is a crisis hanging over our heads. It is not here now because we are able to find ways and means of finding beds for veterans or of giving them the veterans' independence allowance so that they can remain in their own homes. However, we pointed out that situation will not continue. The crisis will only get worse.

Veterans Affairs would require anywhere from 6000 to 10,000 additional priority access beds during this 'crisis period,' Chadderton predicted. In a hard-hitting three part series on veterans hospitals published in the Legion magazine between 1999 and 2000, author Tom MacGregor also shed light on the problem of three year waiting lists for admission to facilities in Victoria, Ottawa and Halifax. 'It is up to VAC to provide the veterans beds when they are needed, whether that means building new facilities, building additions, or contracting beds in other facilities.' In a tough editorial on his revelations, the Legion argued, 'We have been too comfortable with the view long put forward by VAC that Canadian veterans are treated better than veterans anywhere else in the world. VAC should immediately develop and implement national standards of care for institutionalized veterans. VAC should tackle the remaining problems of outdated facilities. VAC should

also address the situation in Victoria, Ottawa and Halifax where the facilities are modern but the waiting lists are intolerably long - up to three years. There's a simple solution: more beds.'

For senior officials within Veterans Affairs, however, the answer was not that simple. 'We had enormous pressure from the veterans' organizations, and rightfully so, that we didn't have enough beds. That we had long wait lists,' John Walker, the department's director of residential care recalled.

But to try and figure out how many beds we were supposed to have was virtually impossible. Impossible. We studied it in 1988. It was studied for a full year. And the projections weren't far off, actually. But we would have never got that many beds... Because we went out and tried to build beds with the provinces, and they weren't interested because they were going the other way. And beds are expensive. And we said we needed them for twenty years in 1990 and we'd pay two-thirds of the capital. And we had no takers. Well, we did get a few, but virtually none. So all of a sudden we'd sit back and say...'We got a problem here. It takes five years to build a bed, at least. Even if you had the money. It's a \$100,000 to build a bed. And now we're only going to need it for ten years or whatever....We got a problem.' So it was a bit of, 'Oh, we got to think outside the box.'

Given the intense pressure Veterans Affairs was facing from veterans organizations over the waiting lists question as well as the uncertainty surrounding the long-term care

needs of OSVs, department officials realized they had to do something. The issue also provoked vigorous discussion among senior officials, leaders of veterans organizations, and gerontological experts within the department's newly formed Gerontological Advisory Council at their second meeting in Charlottetown in the spring of 1998. Cliff Chadderton continued to insist that there was simply not enough contract beds. Legion service bureau director Jim Rycroft suggested that the VIP be extended to overseas veterans in order to reduce the pressure on priority access beds, which was their only benefit. Evelyn Shapiro, one of Canada's leading authorities on home care and someone who had played a central role in the creation of Manitoba's public home care system, argued that the department 'should look at all the alternatives before creating new beds.'

The route eventually taken out of this impasse combined part of both Rycroft's and Shapiro's advice. Verna Bruce, associate deputy minister of Veterans Affairs, offered a vivid description of how the decision was arrived at.

It actually came from...a conversation that we got into one day in deputy minister [Larry Murray's] office...Darragh [Mogan] and Brian Ferguson [were] in the room and...people at that time started to think about, 'okay, is there something we can do with the waiting list at least of three of these contract facilities to try to find a way of managing them...to take the pressure off because it's difficult for families and difficult for the organization and for everybody?' We looked at the idea, 'well, for Perly-Rideau, could you relocate some of those people to a bed at St. Anne's Hospital?' [in Montreal] because at the time St. Anne's... didn't have a waiting list. The thought was...'well, these people are from Ottawa and it's only a two

hour drive.’ But then you start to think ‘that’s a two hour drive and people will be very concerned about whether, if they take a bed at St. Anne’s, are they ever going to have an opportunity to get back to Ottawa, to a bed at Perly-Rideau? And what would it take to keep these people at home?’ Then the conversation... went from there to “well...in other instances we have ‘deemed’ people to be eligible.” We have this ‘deeming provision’ under War Veterans Allowance where we say, “even though you’re not eligible based on your income right now, we ‘deem’ that you would have been eligible if you didn’t have this particular source of income. And once we do that we can put you into the program.” So we created a solution around this. ‘Maybe what we could do is deem these people to be eligible for a bed, but a bed isn’t available so we’re going to provide them with something else in the interim and then see how they get along with that.’ Basically that’s where the idea came from. It was a way of taking pressure off three of those facilities, a way of trying to deal with pressure that was coming from veterans’ organizations around construction of beds...That’s a huge investment of money and who knows if you’re ever going to want it? And we know that people don’t want to be in institutions, so why would you put a whole lot of money into building beds that people may not want in the long run anyway? So the idea came from those...public reactions and program imperatives and again, from really creative thinking by Darragh that maybe we could try doing it this way. So we did.

With the basic policy idea now in play, John Walker was assigned the task, in February 1999, of devising a pilot project proposal to relieve the waiting list pressure at

the three facilities in question: Perley-Rideau Veterans Health Centre in Ottawa, the Lodge at Broadmead in Victoria, and Camp Hill in Halifax where the problems were most severe. It was a “great example of a ‘client-centred’ way to resolve a big problem,” his colleagues observed. The OSV Pilot Project which emerged was targeted at 139 OSV veterans on waiting lists at these three facilities, who were eligible for a priority access bed, when one became available. They would be deemed eligible for both VIP and treatment benefits even though under the department’s legislative authority, they did not have the right to receive either because they lacked a pensionable disability or the required income qualification. ‘The concept was because we couldn’t provide beds to veterans who had a legitimate legislative right...to a bed, we would offer them VIP services in their home until such a time as a bed became available,’ former deputy minister Larry Murray recalled:

Although we didn’t have the legislative authority for that, in my opinion, we did have certainly the moral authority in terms of the intent of the legislation and it was something that we really did want to have a look at [to see] what kind of difference it would make. The other reality is that...it was a quarter to a fifth of the cost to provide veterans services in their own homes than in a facility. So...the pilot was launched in the three centres to have a look at what would be the result.

The project ran for one year between June 1999 and May 2000. Through it the 139 OSV clients gained access, via the VIP, to home patient care, personal care, house keeping, grounds keeping, ambulatory health care, social transportation and home

adaptation services plus Treatment Account Processing System (TAPS) benefits to an estimated annual cost of \$10,400 per client. The OSV clients were not to be 'entitled' to VIP or TAPS. Instead they had 'access to the programs and services they need,' until a priority access bed became available. The key objective was to reduce pressure on waiting lists at the three facilities. However, if successful the strategy would also be less costly (by a factor of four or five) than providing institutional care, and could be extended to other facilities with OSV clients across the country. The OSV pilot project represented the department's first attempt to address the Auditor General's concerns about the needs of the so-called 'phantom group' of veterans. It also provided a concrete example of how the new client-centred service approach could be used creatively to address the unmet needs of clients in a cost effective manner. The VIP benefits and services they received improved their health care as well as their life style while they were on the waiting list by allowing them to stay closer to their families for longer periods; and reduced pressure on and provided respite for their caregivers. Through the project Veterans Affairs gained first hand knowledge of the waiting list problem, as well as the benefit of having to provide fewer additional beds. It was the 'least cost option...for meeting the needs of OSVs.'

Although the project received the approval of the Senate Sub-committee, the VAC Gerontological Council, and veterans organizations, Cliff Chadderton remained deeply skeptical. "Veterans Affairs decided that they would bring in something called 'VIP-like services' as a pilot project,"he told the Senate sub-committee while the project was being implemented in 2000.

Let me explain what that is. The veteran is on the waiting list to get into Perly-

Rideau. They will say to him ‘We will take you off the waiting list. We will send you back home and we will give you VIP-like services.’ That means they will bring people in to cut your toenails and look after you at home. They will also provide someone to shovel your snow, et cetera. We welcomed that as a stop-gap - in fact it is a band-aid measure. It did not reduce the waiting list by one. And we checked. VIP-like service is a pilot project in three areas in Canada. As far as we are concerned, it will not correct the situation at all. What is the solution? It is the one that the current minister announced in June, that is, the federal government will have to go the provinces and say...’We would like to dedicate...more beds.’

Chadderton’s critique was soon eclipsed by the key finding of the project. The OSV clients on the wait lists did not want a bed. Although very frail and quite ill, if given a choice they wanted to stay at home. Ninety-two per cent of the clients who participated rated the services they received as ‘very important or important in helping them remain at home.’ When Veterans Affairs officials had to follow Chadderton’s appearance at the Senate sub-committee meetings, someone suggested that ‘maybe what we should do is canvass the people who are currently on the OSV pilot and find out how many of them if a bed became available in the next week would take it,’ Verna Bruce recalled. “So we had solid information to take with us to the committee....That...created another whole conversation at the standing committee which got away from ‘how many beds do you need to build?’ to ‘wow, you’ve actually provided a service to 96 people and only 5 of them would take a bed if it were offered.’ So you have some empirical evidence you can use rather than just anecdotes about ‘John Smith would rather be at home.’”

Because of the insights provided through the OSV pilot project, it was now clear that wait lists were somewhat illusory. As John Walker told the committee, 'Just by way of illustration, the wait list for the Perley in Ottawa is certainly one of the longest in the country. We had 17 empty beds this January and February and we had to call 50 veterans on that waiting list to fill them ' Or as Darragh Mogan pointed out 'even though these people could have gone into a bed, when we knock on their door and tell them their bed is ready, they say that they would rather stay at home. I think that is probably the hallmark of success and it really means that the VIP program is meeting its objectives.' As a result of these findings, within a year the OSV pilot project was expanded to all overseas veterans on priority access waiting lists across Canada. Once again the same pattern was discovered. A random sample of 170 of the 480 participants were contacted by telephone and provided with a choice. They could accept a bed placement or stay in their own homes with VIP and treatment benefits. Ninety per cent chose to remain at home. The primary goal of the pilot project was to deal with waiting lists, not to find cost savings. But in their analysis of the OSV project evaluators 'found that the cost of maintaining a veteran at home [was] significantly lower than the cost of a priority access bed. The average client on the pilot project spent approximately \$3600 in VIP services and \$3000 in treatment benefits in a 12 month period. The cost of a priority access bed such as the Perley and Rideau Veterans' Health Centre is approximately \$50,000 a year.'

Figures like these finally drove home to the central agencies in Ottawa the cost effectiveness of the VIP. 'The conversion, and it was like St. Paul on the way to Damascus, the epiphany for most of the central agencies, was just only three or four years ago when they looked at this Overseas Service at Home Veterans Pilot Project,' Darragh

Mogan recalled. 'These people were extremely ill, extremely ill. ... We looked at one hundred phone calls made in Ottawa, a hundred to people who would be certified by the province as being Type 2 or even Type 3, not one would go in, not one. Zero. And the same thing happened at Camp Bell, the same happened at Broadview. That was the proof. ... As if proof were needed. Everybody was a doubting Thomas. But the central agencies saw that and they knew what they saw. They saw files, they knew how sick these people were and they were still willing to stay home.'

After two decades of pioneering Canada's most extensive model of community-based home care, officials responsible for administering the VIP now had convincing evidence that even Type 2 and Type 3 clients whose need for expensive institutional care was immediate and irrefutable, when given a real choice backed by a strong network of home care resources, preferred to 'age in place' rather than within a long-term care facility. In this sense the OSV Pilot Project provided Veterans Affairs with strong arguments to counter the sheer power of waiting lists to drive the agenda towards purchasing or building additional beds. 'People love beds...they love institutions. They love it for everybody else but they don't love it for themselves though,' Judy Lougheed wryly observed. 'So none of [this] was really surprising. I think that what is surprising is that the numbers are even lower than what anyone would have predicted. I think it's a reflection of the care we've been giving people at home.' Or as John Walker put it, 'people don't want long-term care. But if it's the only thing, if you say, 'sir, we can give you long-term care or we can give you nothing. Because they can't keep up any more on their own, they'll say, 'well ok, I'll take the long-term care.' Or 'no. I'll just go down in flames here.' And perhaps in the past, unfortunately, that did happen. But now we can say

‘well there’s no bed for you yet, but we can give you this.’ It’s worked...It made sense....So if anyone wants to review the impact of the Veterans Independence Program they have to look at that pilot.”

In this sense, the original arguments of Ferguson Anderson and Jack MacDonell used to justify the creation of the VIP in the late 1970s were validated through the OSV pilot project but this time for a much frailer clientele. In June 2003 eligibility for the VIP would be extended to all overseas service veterans who demonstrated a need for the program. More research questions still remained, however. How long could access to the VIP and treatment benefits delay institutionalization? To what extent was the decision to remain at home attributable to the resources made available through the pilot project as opposed to other factors? And what was the impact on caregivers? In assessing the ‘cost’ advantage of the VIP it always had to be remembered, Darragh Mogan acknowledged, that ‘for most recipients, the care and support provided by family members (most often the spouse) comes at no cost to the state.’

The needs and rights of spousal caregivers of veterans re-emerged forcefully onto Veterans Affairs policy horizon during the same time period as the debate over waiting lists was unfolding. Along with better access to beds it was the other key demand of veterans organizations throughout the later 1990s. Their concerns also received significant support from the research focus on caregiving by social workers and gerontologists in the late 1980s and 1990s, which had also helped to spark the department’s interest in the ‘Care for the Caregiver’ program as well as by the Review of Veterans Care Needs Project launched by the department launched in 1996.

Concern for spousal caregivers of veterans had been an ongoing theme within the

VIP since its inception. It strongly informed the work of Jack and Asa MacDonell at the Deer Lodge day hospital which helped to inspire the original Aging Veterans Program. The ongoing importance of spousal caregivers to the success of the program was also clearly recognized by Veterans Affairs counselors. 'It goes really back to the very root of the program,' Duncan Conrad recalled, 'Whenever a counselor went into a veteran's home, the interview was always with the veteran and the spouse....So as the program evolved it started the recognition of the fact of the role that those individuals played.' Within six months of the AVP's launch in 1981, some regional directors were suggesting that 'the spouse of the veteran should be eligible for contributions...in order to keep the couple at home'. The discussion paper on the extension of the AVP in 1983 also pointed out that 'no mention [had been made] of spouses and their vital role in maintaining the well-being of entitled veterans. Their capacity to fulfill that role and their need of assistance to do so will be fully recognized in the execution of the program, based on the understanding that husband and wife epitomize the highest degree of mutual support and reliance.' Despite this acknowledgement that the husband and wife were a caregiving 'team', the document remained silent on the issue of the rights of the spouse when the veteran died. The only departure from this position was the decision in 1982 to continue providing housekeeping and benefits in force at the time of the veteran's death to the spouse for up to 30 days 'or when other arrangements have been made, whichever is sooner.' The operating principle was that the benefit was 'provided *to the residence of the client* and is thus *implicitly provided* to both the client and the spouse.' No direct personal entitlement was enjoyed by the non-veteran partner.

In 1990 in response to a Legion campaign launched in 1987, Veterans Affairs

agreed to extend VIP benefits already in place for housekeeping and groundskeeping to the spousal caregiver for 12 months from the time of the veteran's death, recognizing that the 30 day termination was 'causing hardship at a very difficult time.' The 12 month extension would prevent the spouse from having to 'make a premature move from the family home' and also was 'consistent with other [Veterans Affairs] benefits which, in most cases continue for a period of up to one year following the veteran's death.' Nonetheless, due to concerns about 'policy creep' the extension was hedged with conditions. To avoid setting a precedent for paying health benefits to a dependent, the department insisted that 'only the termination date of certain VIP elements is being extended and that eligibility to a spouse is not being recognized; eligibility still resides through the veteran.' If the spouse changed residence within the 12 month period the benefit would terminate. In no case did the department wish to prove a foothold for arguments in favour of paying 'other benefits/services to spouses and dependents.'

Veterans Affairs sponsorship of the 'Care for the Caregiver' program and workshops between 1992 and 1994 kept the profile of caregiver needs and concerns high within the VIP, and clearly sensitized department staff around these issues but in the context of fiscal restraint policies and benefit cutbacks in the early 1990s there was little scope for moving beyond the 1990 policy amendment liberalizing spousal VIP benefits for 12 months. By the mid 1990s, however, the needs of caregivers within the program were gaining greater attention. The Client-Centred Service Initiative, as discussed previously, clearly represented a philosophic shift not only within the VIP but within the entire department as well towards a more holistic and family-centred focus on needs rather than entitlements. From this perspective, the role and contributions of veteran caregivers to the

ability of a veteran population, now past age 75, to continue living in their own homes, could not help but be brought more sharply into view. In 1996 this approach received a major boost through the creation of the Review of Veterans' Care Needs Project. In 1997 the RVCN project conducted a series of 12 focus groups in cities across Canada with veterans, their caregivers, and service providers. Its report on these discussions, prepared by Pollara consultants, provided a critical forum for veterans and their caregivers to talk frankly about the strengths and deficiencies of the VIP. 'Why does Veterans Affairs not treat wives the same as we are?', one veteran asked. 'Spouses are part of us; they suffered with us and they should be compensated. If I pass away my wife is out in the cold.' Their partners expressed similar feelings. 'We are caregivers of veterans. They will give you service as long as the veteran is living. If he dies, what will happen to me? Will all those benefits be cut off?' Summing up the concerns they had heard during the 12 focus group sessions, the consultants noted that 'these caregivers thought that the services available to their veteran spouses should also be available to them. Some felt very strongly that, without their assistance as a caregiver, the costs of caring for the veteran would be much higher for DVA. Thus, they rationalized the extension of veterans' services to include spousal caregivers.' The Pollara report also concluded that

Caregivers' isolation, loneliness, and fear were central to the 'last piece of advice' given by the caregiver group participants....The caregivers' concerns were concentrated in a few important areas such as the sense of isolation and being 'all alone out there.' Their expressed **isolation** and **loneliness** as caregivers, could as stated, be linked to their strong articulation of their fear **of losing benefits**. The

degree of fear of losing benefits may well be associated with the fear of other participants with regard to the caregivers' lack of **spousal benefits**.

All of these concerns about the needs of spousal caregivers surfaced between 1997 and 2003 in other key forums both internal and external to the department. The formation of the Veterans Affairs Gerontological Advisory Council in 1997 created a new and important vehicle for triangulated discussions among department officials, veterans organizations, and academic experts for connecting the needs of veterans and their spousal or other informal caregivers. Council members Neena Chappell, Evelyn Shapiro and Norah Keating had long been among the leading advocates within Canadian gerontology for policy recognition of caregiver contributions. Not surprisingly, one of the first suggestions they made for Council research priorities was the topic of veteran spouses or caregivers. Within a year Keating was chair of a working group on 'caregiving' for the GAC exploring, among other topics, the 'continuation of VIP...after the death of the veteran.' With the urging of representatives from veterans organizations, by its May 2000 meeting the council was recommending lifetime spousal eligibility for the VIP, although Veterans Affairs officials stressed the need for more research and cautioned that if 'the agenda is pushed hard, they could get nowhere [because] money is a large obstacle.' This was a position which caused some veteran representatives temporarily to boycott the GAC during the next year.

Both the Legion and the National Council of Veterans Associations, however, pushed hard from 1997 onwards for lifetime spousal benefits to the VIP for widows of veterans at their regular appearances before the Senate Standing Sub-committee on

Veterans Affairs. 'The Veterans Independence Program...helps keep the veteran in his home. It is important that a spouse remain in the home as long as that spouse is capable of managing, perhaps with some help,' Jim Rycroft, the Legion's Service Bureau director argued.

It only seems to make sense that if Veterans Affairs is already tied in to the care of veterans and their spouses through disability pensions, through proportionate pensions for survivors and so forth, that they take on the role with respect to spouses. They seem to recognize it by acknowledging that respite care and other care is a necessity. We are saying that they should rationalize that process and then work to provide a solution that does not cut the widow off when her husband dies after a year, but continues as long as that person is capable of managing the home.

Cliff Chadderton of the NCVA agreed. 'These are caregivers, most of them 50 years in the saddle. They could not go out and get jobs because they looked after their veteran spouse all those years. One year after his death she is cut off...Certainly the Veterans Independence Program should continue for her life if she is capable of living in the house.' Four years later lifetime eligibility to the VIP for widowed spouses of veterans had become the Legion's 'top priority.' By this point the rising mortality of its mostly male Second World War membership, now in their early 80s, had sharply underscored the concern of veterans for what would happen to their wives when they were gone. 'Certainly in the mind of the veteran, that program was taking care of both of them - allowing both of them to live in the house,' Rycroft told the senators in 2001. 'We are

trying to honour the veterans' wishes to take care of the surviving spouse. That is the proper thing for Canadians to do....The Veterans Independence Program could solve the problem for \$2500 to \$4000 per year.'

The Legion's arguments received partial support from a major report by Norah Keating, Jacquie Eales, and Janet Fast that same year on 'The Differential Impact of Veterans Affairs Canada Policies on the Economic Well-Being of Informal Caregivers,' commissioned by Veterans Affairs. Unlike veterans' organizations, however, Keating, Eales and Fast put forward a much broader agenda for policies which would recognize the full range of caregiving contributions within veterans' families. "A policy of 'equal support for caregiving work of equal value' is required," they argued. If the department's mission was to 'support...veterans and their families, then benefits should be extended to all veterans.' That would include compensating not only caregivers *of* veterans, but caregivers who *were* veterans as well as caregivers of veterans not currently clients of the department. Under this policy framework, widowed spouses would receive eligibility for the VIP beyond one year. But they would also be eligible for benefits derived from the Veterans Health Care Regulations. Keating, Eales and Fast also argued that Veterans Affairs should provide 'financial compensation to informal caregivers who have reduced or forfeited paid employment to provide care, or in regions in which unemployed caregivers are providing substantial amounts of caring work,' and that the department move beyond a client-centred to a family-centred approach to meeting needs. As the experience of the VIP indicated, 'attempts to support caregivers with policies developed to support care recipients are cumbersome. We argue that as VAC moves towards a focus on the veteran family unit, it should be prepared to provide direct benefits to informal

caregivers,' through existing programs for veterans such as the veterans health care regulations and Attendance Allowance. This was an ambitious policy agenda which incorporated but went far beyond the issue of lifetime extension of VIP to widowed spouses of veterans.

Over the spring and autumn of 2003 the six year campaign of veterans organizations to achieve lifetime eligibility for veterans' widows to the groundskeeping and housekeeping provisions of the VIP, in place at the time of their husband's death, was rewarded with success. In a two stage process Minister of Veterans Affairs Rey Pagtakhan first announced in May 2003 that surviving spouses would become eligible for lifetime grounds-keeping and house-maintenance services of the VIP, in place at the time of their partner's death, as of 1 June 2003 if such access allowed them to remain self-sufficient in their own homes. However, eligibility would not be made retroactive to wives whose husbands had died before that date.

This decision created a summer and autumn of discontent around the creation of what veterans organizations, veterans wives, and members of Parliament termed "two classes of veterans' widows, those who received VIP benefits for the remainder of their lives and those who did not because of an 'arbitrary date.'" The very widows 'who had lobbied the minister that these benefits be ongoing would get nothing...[I]nstead, ...the only ones now receiving the veterans independence program...are those whose husbands died in the last year. Why will the minister not treat these veterans' wives equally and give benefits to past recipients of the VIP?' opposition MPs asked. Whatever the fiscal logic of this decision, the political optics of leaving between 23,000 and 28,000 veterans widows without VIP support were terrible. If anything these women were older, frailer, and more

in need of housekeeping and groundskeeping services to keep living independently than their more recently widowed counterparts.

In October 2003 backbench Liberal M.P. Bob Woods introduced a motion in the House of Commons, which received unanimous support, urging that lifetime VIP eligibility for widows be made retroactive. A month later prime minister Jean Chrétien intervened personally to repair the damage. On 6 November, Veterans Affairs minister Rey Pagtakhan announced in Parliament that VIP eligibility would indeed be extended retroactively to qualified surviving spouses whose partners had died subsequent to 1990, the year when the original 12 month extension of VIP to widows was first put into place. Still left out in the cold, however, was another arbitrary category: veterans wives widowed prior to 1990.

By the end of 2004, in response to persistent lobbying by veterans organizations and veterans widows, the exclusion of this remaining group was finally addressed. On 7 December 2004, Veterans Affairs minister Albina Guarnieri announced that housekeeping and groundskeeping services in place through the VIP at the time of the veteran's death would be extended retroactively for life to primary caregivers of veterans, principally their widows, dating back to 1981, the year the Aging Veterans Program was originally created. 'This is a beautiful Christmas gift for these people who were not included in the last VIP announcement,' Kenneth Henderson, Dominion President of the Army Navy and Air Force Veterans in Canada pointed out. Mary Ann Burdett, Dominion President of the Royal Canadian Legion also commended Veterans Affairs for 'adopt[ing] a policy which is more consistent with their traditional client-centred approach to service delivery.' The decision was expected to bring an estimated 4,000 additional clients into the scheme at a

cost of \$31.7 million over the next five years.

The granting of lifetime spousal eligibility to the VIP for veterans widows who needed housekeeping and groundskeeping services constituted an historic shift in the department's mandate. For the first time not simply service in time of war, but caregiving in time of peace was being acknowledged as conveying a right to assistance for living independently in the community. It was an important step towards expanding the relevance of the VIP homecare model to a wider Canadian audience.

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CONCLUSION

Over the past 23 years the Veterans Independence Program has evolved from a small 'pilot project' serving fewer than 300 disabled veterans in 1981 to become the acknowledged 'flagship program' of Veterans Affairs helping to keep almost 70,000 elderly veterans and their spouses living in the community. As the 1998 Review of Veterans' Care Needs project pointed out, 'veterans want to remain independent in their own homes or communities as long as possible.' When asked, in focus group discussions, what Veterans Affairs services they thought were most important, 'without fail, most said the VIP program was the most important service upon which they relied. All indicated they would be unable to maintain their homes without it.'

These remarks echo similar high levels of satisfaction expressed by VIP users during the 'Care for the Caregiver' sessions of 1993-94 or to the Price Waterhouse evaluation of the program in 1987-88. They were also powerfully underscored by the results of the Overseas Service Veterans pilot project in which even veterans with high care needs, when given the choice between access to a long term care bed or assistance to remain living in their own home, chose the VIP model nine times out of ten. The program's explosive caseload growth beginning in 1985 and continued popularity over the ensuing two decades confirmed the wisdom of the original vision which inspired it. Whether in their sixties or their eighties, older people, as Ferguson Anderson argued, 'are happier and healthier in their own homes if they are fit enough to be there and so desire.' Veterans, more than any other group of Canadian seniors, have been given the widest range of support to make this choice possible.

That this was so reflected a combination of circumstances: the strong desire of veterans to continue living independently for as long possible; their status as ‘very special Canadians,’ or ‘citizens plus’ because of war service and subsequent entitlement to enhanced support in old age; the need of Veterans Affairs to find a less expensive alternative to the anticipated doubling in costs of institutional care by the mid 1980s because of the aging Second World War veterans’ cohort; and a cadre of creative policy thinkers within the department who, as Darragh Mogan notes, were anxious to find ‘an alternative to the warehouse’ so that their clients could grow old in comfort, security, and dignity. Second World War veterans and their caregivers were also an advance guard of the ‘grey wave’ which would soon wash over the rest of Canadian society. Much of the excitement of building the VIP clearly reflected the awareness, by Veterans Affairs officials, that in developing a national home care strategy for their clients the department was pioneering new policy terrain with potentially important lessons for an aging Canada.

The VIP’s rapid growth and enduring popularity among veterans’ families is evidence of both the attractiveness and need for community based home care strategies which provide a broad continuum of support for aging in place. The most widely used elements of the VIP, self-managed housekeeping and groundskeeping services, although not generally available within provincial homecare policies, have arguably played a key role in bringing veterans into care plans designed to avoid a caregiving crisis. ‘It’s the VIP services, the support services for seniors that makes home care an efficient program,’ Betty Havens, one of North America’s leading authorities on the topic argues. ‘Home care becomes more effective if you’ve got these minimal resources that are either volunteered, levered, or paid...Putting those things together is part of what supports

caregivers. And if you want to have informal caregivers providing 80 per cent or more of care - which is where we are at the moment -then you better be able to support your caregivers or you are going to wind up with two clients.’ Or as one veteran’s wife put it, ‘if we don’t get help you are going to have two of us going to a nursing home.’ Insights such as these informed the VIP from its inception. Building on them has been one of its lasting legacies.

Has the VIP been cost effective? This is an argument which has typically driven policy debates around home care in the rest of Canada and the United States. Since the program’s original rationale was premised on its ability to avoid the need for doubling the supply of institutional beds funded by Veterans Affairs by the mid-1980s this was not an insignificant concern for government. At every stage of its history department officials have argued that the VIP saves money. Estimates of how much have varied. Seven to one, eight to one, and ten to one differentials between the average annual cost of VIP home care services per client and the cost of an institutional bed were put forward by Veterans Affairs officials as a justification for program expansion at different points throughout the program’s life. More recently a four or five to one differential was used in making the case for the cost-effectiveness of the Overseas Veterans Pilot project.

During the late 1980s the Price Waterhouse study tried to devise a global estimate for the cost-savings generated by the VIP but without knowing what choices veterans and their families would make in the absence of the program, the exercise was problematic, as both the consultants and Veterans Affairs officials conceded. There is a clear consensus within the department and among the leaders of veterans’ organizations, however, that the VIP has reduced the demand for beds. More to the point, money not spent on institutional

care has allowed tens of thousands of veterans and their caregivers to benefit from VIP home care services.

Bed-avoidance rather than cost-saving perhaps provides a more accurate description of the VIP's impact since the program has provided an opportunity to question the meaning of waiting lists for institutional care. Veterans' impatience with waiting lists at institutions such as Sunnybrook Hospital in the mid-1970s helped to spark Veterans Affairs' original interest in searching for less expensive alternatives to domiciliary care. A quarter-century later, long waiting lists for priority access beds in Ottawa, Victoria and Halifax inspired the creation of the Overseas Service Veterans Pilot Project. Out of this experience emerged direct evidence that waiting lists, in and of themselves, are a dubious guide to what people want if given a choice. How many veterans have avoided institutionalization because of the VIP is unknown and likely unknowable. That they prefer using it to stay at home, if at all possible, rather than accept the offer of a long term care bed is clear.

Veterans have such a choice because they are privileged clients of the Canadian welfare state in recognition of their sacrifices in time of war. Their right to federally-funded long term care beds, for example, was the program's original policy driver. A tension between entitlement and need, which has only grown in urgency as veterans become older and frailer, has shaped the VIP's evolution over the past 23 years. Pensioners with a war-related disability were the program's first clients even though their need for its services, in many cases, was less than that of low income veterans in receipt of a War Veterans Allowance. As eligibility expanded rapidly, during the George Hees era of 'courtesy, generosity, and speed,' higher need client groups joined the VIP caseload in

large numbers easing this discrepancy, although pensioners remained a larger than anticipated component of the program's caseload. However, by 1990 a new era of fiscal restraint forced a difficult reorientation of the VIP away from what some termed a 'culture of generosity,' and towards tighter enforcement of eligibility criteria at the same time that its clients were becoming older and frailer. Out of this conjuncture of circumstances emerged the search for a new approach to service delivery focused on risk-screening, a more holistic and multi-faceted approach to interpreting needs and eligibility, and the redirection of counseling resources to where they were most required.

Between 1985-1995 the policy environment within the department shifted dramatically away from efforts to actively recruit clients for the VIP through 'ascertaining' veterans with unmet needs and towards policies of fiscal restraint and risk screening. During this period of change Veterans Affairs area counselors faced difficult administrative challenges which caused frustration, staff burnout, and growing tension between department headquarters and district offices. Staff trained principally as benefit administration officers in an earlier era had the most difficulty in making the adjustment. Those with social work or gerontological training, (a majority by the late 1980s) adapted more easily to the transition. Nonetheless complaints about large caseloads, inadequate training, the growing intensity of their clients' needs in relation to VIP eligibility requirements, and a perceived organizational culture of 'over-control' became recurring refrains repeated within external audits and evaluations of the program. The too rapid and top-down implementation of advance pay in 1992 as a way of 'streamlining' the costs of VIP administration brought these tensions to a head. Out of the unhappiness produced by this experience emerged a shift towards formal staff consultation through the creation of

the Field Advisory Committee. FAC recommendations helped to usher in new delivery strategies providing more discretionary authority for district office staff, the development of standardized assessment tools, and risk-screening procedures, and a new emphasis on client-centred rather than program-driven service. This client-centred service approach has now become the organizational philosophy for Veterans Affairs as a whole. But its origins within the department can be located in the challenges and leadership emerging out of the VIP.

The Veterans Independence Program began in 1981 as a program targeted overwhelmingly towards the needs of male veterans, although the much smaller number of women veterans also benefited. Although the central role of spouses in maintaining veterans 'independence' was acknowledged by the program's designers, it remained muted throughout the VIP's first decade. On the one hand the ideology of familialism which underpinned the program insisted that the caregiving labour of wives (and other household members) for veterans was simply part of the 'normal responsibilities' of the family. In no way should the VIP undermine these traditional roles and obligations. In this way the costs to and contributions of caregivers to veterans' 'independence' were rendered invisible as were the capital costs of the veteran's house as the site of care. On the other hand, since the entitlement to VIP derived from the veterans' war experience, any benefits or support gained by their wives, principally through the provision of housekeeping and groundskeeping services, were implicit and indirect rather than derived from their own services as caregivers. When the veteran died, VIP came to an end after 30 days. In this sense veterans' benefits simply exaggerated the hierarchical breadwinner ideology which had long underpinned the larger structure of the Canadian welfare state.

By the 1990s these twin assumptions - familialism and the exclusivity of (mostly male) veteran entitlement were becoming unstable. New research was exploding the 'independence' or 'autonomy' myth by highlighting the interdependency of family life among the elderly (and others) and its hidden costs to caregivers. Within Veterans Affairs these realities had long been apparent to counselors through their firsthand work with veterans and their families. The cost-savings of the VIP and the reality of veterans independence really rested on a foundation of unpaid female labour. As veterans themselves grew older, their demands for recognition of their wives' sacrifice and right to live with dignity as widows became louder. So too did the voices and the contributions of the women themselves as the care demands of their partners intensified. 'We are the caregivers of veterans...If he dies what will happen to me?,' they told the Review of Veterans' Care Needs project. As its report pointed out, the demand of wives for continued VIP services "was seen as a 'return' or 'compensation' for the commitment they made to their veteran spouses." This demand achieved recognition between 2003 and 2004 with the granting of lifetime eligibility to selected VIP services for veterans' widows (or other principal caregivers), on proof of need. In the process, an historic shift in the mandate of Veterans Affairs through the state's recognition of a new form of service has occurred.

Does the VIP represent a home care policy model for the rest of Canada? Have Veterans Affairs and Canadian veterans pioneered the way for other Canadians in need of assistance with daily living as they reach old age? Here the answers are mixed. There is no question that the Veterans Independence Program has demonstrated the importance and viability of a community based home care alternative for veterans and their families

across Canada. The overwhelming satisfaction of its clients with the services received through the program is testimony to its success in realizing its objective of keeping veterans in their own homes as the preferred alternative to institutional care. Whether the lessons of the VIP reach a wider Canadian audience, however, depends on the extent to which the entitlement itself is seen as unique to veterans. As the Review of Veterans Care Needs pointed out “because many veterans believed they had a right to services ...[they] were more ‘open’ about what they needed....Services such as the VIP are acceptable to them because VIP is a service that they have earned and they get it from DVA.”

This is a sentiment American political sociologist Theda Skocpol, in her study of the G.I. Bill of Rights, has termed ‘legion populism.’ But as the U.S. example illustrates, legion populism does not always translate well into claims which are easily winnable by a wider public. Today American veterans enjoy a range of publicly-financed medical and hospital services which Canadians have long taken for granted as part of their basic medicare entitlement. Veterans health care benefits south of the border, however, have not led to a successful American campaign for universal, publicly-funded health insurance. A similar challenge confronts those arguing for the addition of something like the VIP home care model to our national health care package. For this to occur, VIP-like services must first be seen as essential and affordable, not just for ‘very special Canadians,’ but for everyone who requires them. The transferability of the VIP model to the larger Canadian health care domain will depend, in the final analysis, on whether all Canadians, not just veterans, believe that they too have earned a similar right to comfort, security, and dignity in old age.

NOTES

Appendix 1

Veterans Independence Program Chronology

- November, 1980** Aging Veterans Program announced by J. Gilles Lamontagne, Minister of Veterans Affairs.
- April, 1981** Aging Veterans Program introduced for war pensioners for pensioned conditions.
- August, 1981** Regulations gazetted to phase-in new eligibility groups between October, 1984 and January, 1988.
- October, 1984** Eligibility extended to War Veterans Allowance recipients, age 75 and to dual recipients (WVA-and CPC pensioners), age 65.
- January, 1986** Eligibility extended to WVA recipients, age 65.
Name of program changed to Veterans Independence Program.
- October, 1986** Eligibility extended to WWI near-recipients, (i.e those who would be receiving WVA if they or their spouses were not receiving OAS)
- January, 1988** Eligibility extended to remaining veteran near-recipients.
- April, 1989** Eligibility extended to Canada Service Veterans age 65.
- September, 1990** Housekeeping and groundskeeping services in place at time of veteran's death may be continued for the surviving spouse for up to one year following the death of the veteran.
- June, 1991** Eligibility extended to special duty area pensioners for their pensioned condition.
- July, 1992** Eligibility extended to Merchant Navy Veterans.
- June, 2003** Lifetime eligibility for housekeeping and groundskeeping services in place at time of veteran's death may be continued for surviving spouses whose partners died after 1 June 2003.
- November, 2003** Lifetime eligibility for housekeeping and groundskeeping services in place at the time of veteran's death made retroactive for surviving spouses whose partners died subsequent to 1990.
- December, 2004** Lifetime eligibility for housekeeping and groundskeeping services in place at the time of veteran's death made retroactive for surviving spouses whose partners died subsequent to 1981.

Appendix 2

VIP Caseload and Expenditure Growth, 1981-2001

Fiscal Year	Number of Clients	Expenditures (\$M)
1981-1982	300	0.2
1982-1983	1,400	1.4
1983-1984	2,900	3.1
1984-1985	5,500	5.9
1985-1986	9,500	13.8
1986-1987	16,200	21.2
1987-1988	24,800	31.3
1988-1989	40,400	54.0
1989-1990	59,700	85.6
1990-1991	71,900	111.6
1991-1992	82,000	135.5
1992-1993	87,900	168.3
1993-1994	85,400	168.4
1994-1995	83,000	162.3
1995-1996	78,900	155
1996-1997	76,000	152
1997-1998	73,200	150
1998-1999	71,500	153
1999-2000	69,700	156
2000-2001	68,900	163

Sources: Veterans Affairs Canada, VIP Records, File 765-8, vol. 10, 'Veterans Independence Program Component Profile,' Table, 'VIP Clients & Actual Expenditures, Main Estimates, Part III), p. 8; Veterans Affairs Canada, Statistics Directorate, Corporate Planning Division, 'Clients and Expenditure Forecasts, 2002-2003 Forecast Cycle, October 2001,' Table, 'Clients by Program, Forecast 2002-2011,' p. 15; Table, 'Expenditures by Program, Forecast 2002-2011,' p. 17.

Appendix 3

VIP Participation by Age Group, March 2001

< 65	16%
66-69	29%
70-74	32%
75-79	61%
80-84	69%
85-89	74%
90+	78%

Source: Veterans Affairs Canada, Statistics Directorate, Corporate Planning Division, 'Client and Expenditure Forecasts,' 2002-2003 Forecast Cycle, October 2001, p. 47

Appendix 4

VIP Participation by Age and Program Element, March 2001

Housekeeping

<65	10%
65-69	23%
70-74	28%
75-79	54%
80-84	60%
85-89	62%
90+	57%

Groundskeeping

<65	13%
65-69	21%
70-74	22%
75-79	42%
80-84	45%
85-89	41%
90+	33%

Nursing Home Care

<65	.25%
65-69	.75%
70-74	1.0%
75-79	2.8%
80-84	3.7%
85-89	7.0%
90+	14.3%

Source: Veterans Affairs Canada, Statistics Directorate, Corporate Planning Division, 'Client and Expenditure Forecasts,' 2002-2003 Forecast Cycle, October 2001, p. 48

Appendix 5

VIP Participation by Age and Program Element, March 2001, Cont'd

Ambulatory Care

<65	.1%
65-69	.25%
70-74	.4%
75-79	1.0%
80-84	1.2%
85-89	1.8%
90+	2.2%

Adult Residential Care

<65	.1%
65-69	.05%
70-74	.15%
75-79	.20%
80-84	.25%
85-89	.35%
90+	1.7%

Social Transportation

<65	.5%
65-69	2.4%
70-74	4.0%
75-79	5.1%
80-84	7.5%
85-89	10.1%
90+	15.0%

Source: Veterans Affairs Canada, Statistics Directorate, Corporate Planning Division, 'Client and Expenditure Forecasts,' 2002-2003 Forecast Cycle, October 2001, p. 49

Appendix 6

VIP Participation by Age and Program Element, March 2001, Cont'd

Nutrition

<65	.5%
65-69	1.75%
70-74	2.4%
75-79	3.75%
80-84	4.74%
85-89	7.0%
90+	10.0%

Personal Care

<65	.5%
65-69	1.2%
70-74	1.3%
75-79	2.5%
80-84	3.75%
85-89	5.1%
90+	8.0%

Source: Veterans Affairs Canada, Statistics Directorate, Corporate Planning Division, 'Client and Expenditure Forecasts,' 2002-2003 Forecast Cycle, October 2001, p. 49

Average VIP Expenditures per Client, 1993-2001

1993	1994	1995	1996	1997	1998	1999	2000	2001
\$1,905	\$1,944	\$1,927	\$1,912	\$1,962	\$2,013	\$2,108	\$2,215	\$2,347

Source: Veterans Affairs Canada, Statistics Directorate, Corporate Planning Division, 'Client and Expenditure Forecasts,' 2002-2003 Forecast Cycle, October 2001, p. 50

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