

Federalism and Suitable Housing for the Frail Elderly: A Comparison of Policies in Canada and the United States

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Abstract

The frail elderly have special multidimensional housing needs beyond affordability, including shelter that is more adaptive to reduced function and offers supportive services. Suitable housing for this population comprises three policy areas—housing, health care, and social services. In a federal system, development and implementation of policies in these areas involves participation of several levels of government and the nongovernmental sector. This paper uses federalism as a conceptual framework to examine and compare these policy areas in Canada and the United States.

In both countries, general national housing policies—relying heavily on the nongovernmental sector and characterized by joint federal-provincial programs in Canada and by important local government roles and age-specific programs in the United States—have benefited the elderly. The effects of such policies on the frail elderly, however, have been less positive because of the general lack of essential human services and, to a lesser degree, health care that enables them to live outside institutions. This is especially true in the United States, where health care policy is fragmented and is dominated by a private insurance system, partial federal financing of health insurance for the elderly, and tense federal-state relations in financing health care for the poor. Although Canadian policies and programs operate autonomously and more uniformly within a national health plan, neither country has a universal, comprehensive long-term care system. Geographically diverse patterns of social services, funded by grants to states and provinces and the nonprofit sector, are common to both countries. However, the United States has inadequately funded age-specific programs and has relied on a growing commercial service provision. Housing outcomes for frail elders are moving in the right direction in both countries; however, Canada seems to be better positioned, largely because of its health care system. As increased decentralization continues to characterize the three policy areas that affect suitable housing for frail elders, the United States can learn from Canada's negotiated federalism approach to more uniform solutions to merging housing and long-term care.

Introduction

Cross-national policy comparisons are often dominated by the view that policy development is particularistic and evolves from a unique sociocultural, political, and historical context, rendering

valid comparisons difficult, if not impossible. Fruitful international comparisons can be made, however, if a conceptual framework, such as federalism, is introduced.

This article addresses the issue of suitable housing for the frail elderly in two federal societies, Canada and the United States. These North American neighbors are linked by history, geography, and heritage, as well as by comparably diverse populations with similar living standards. They also share accelerated population aging, requiring the development of housing to meet the multidimensional needs of frail elders.

Discussions about appropriate housing for the elderly invariably focus on issues of horizontal coordination across programs and services (see, for example, Pynoos 1990). Nevertheless, too little attention has been paid to the *vertical* integration of policy domains affecting frail elders, often because a myopic focus on “national policy” has needlessly obscured the vital roles and actions of other levels of government. Closer scrutiny of federal systems, which involve several levels of government and the for-profit and nonprofit or voluntary sectors, can provide more complete explanations for the patterns in housing policies for the elderly.

This article first describes the federal structures of Canada and the United States and their effects on the policy environment for the aged. Attention is then focused on three policy areas—housing, health, and social services—that comprise suitable housing for frail elders, and how each is apportioned among the three levels of government and nongovernmental institutions in the two countries. The trends in federalism and their implications for suitable housing policy outcomes for frail elders in Canada and the United States are discussed in the final section.

Framework of federalism

Under federalism, a national government and one or more subnational levels of government each have substantial policy-making powers and can make arrangements for working out solutions, making joint decisions, and adopting joint policies (Friedrich as per Nathan 1990, 249–50). The resultant sharing of authority between the national and subnational governments is neither simple nor static. A complex set of relationships emerges that can be categorized as independent/competitive (autonomous), interdependent/cooperative

(negotiated), or dependent/coercive (hierarchical), accompanied by high levels of discretion, incentives, or mandates.¹

Autonomous relations are characterized by clear boundaries between federal and subnational authority. Discrete, appropriate authority is defined for specific levels of government, such as property taxes and land use at the local level, sales taxes and professional licensure at the state level, and defense and interstate commerce at the national level. *Hierarchical* relations are exemplified by mandates from a higher level of government to a lower one, such as requiring uniform standards or new programs, often without financial or technical assistance. This results in less flexibility for the lower level of government. *Negotiated* relations are characterized by give-and-take, developed through formal intergovernmental councils or lobbying efforts, leading to articulated, often shared responsibilities. This can include agreements about the national government's preemption of several areas of taxation, with a fixed proportion of the resulting revenues allocated to subnational governments, or about shared regulation of health and safety in the workplace.

Relations within federal systems are dynamic. Constant shifts blur the boundaries of effective jurisdiction among the several levels of government (Bloksberg 1989; Landes 1983; Stevenson 1985). Both Canada and the United States have recently moved away from an earlier period of effective expansion of national jurisdiction. This decentralization has been accompanied by reduced central government funding, often with fewer strings attached; by greater regional government involvement in domestic affairs; and by heavier reliance on market strategies and the voluntary sector.² The resulting devolution, accompanied by increased variation in policy approaches and solutions, has been hailed as a way to adapt to new social, technological, and economic needs and conditions (e.g., population aging); to afford more points of access for voicing citizen preferences; and to reconcile competing and conflicting diversities, such as the accommodation

¹ Wherever possible, both Canadian and American writers are cited to demonstrate the basic agreement on concepts presented. In this instance, see Burgess (1990), Dye (1990), Hanson (1990), and Leach (1981).

² This theme of involving the nongovernmental sector in addition to subnational governments has been sounded more frequently in recent writings on federalism. See, for example, Brown-John (1990), Chandler and Bakvis (1989), and Pagano and Bowman (1989).

of ethnic, linguistic, and institutional roots.³ However, because of shifts in effective jurisdiction and geographically disparate and poorly integrated policies, it is also seen as expensive, inefficient, and conducive to diffused responsibility.⁴

Federalism in Canada and the United States—An overview

Canada and the United States exemplify the major characteristics of federal systems of government. See table 1 for a summary of their national-regional relationships relative to six consequential powers.⁵ Regional governments in both countries have *legal powers* to establish and revise their own political structures and processes. The U.S. Constitution lists the powers of the national government and their limits; powers not granted to the national level are reserved to the states or the people. By comparison, Canada's constitution is far more explicit about the powers of the provincial governments. Subnational governments in both nations have distinct *functional-area authority and responsibilities*. Canadian provinces, however, have specific constitutional authority for education, law enforcement, and local government affairs, enabling them to bargain more effectively in their dealings with the national government.

Regional governments in both nations, concurrent with their respective national governments, are responsible for health and social services, which can lead to either cooperative or competitive interactions. They also exercise *power over local governmental units*, which are seen as their creations and often as their administrative arms. The U.S. doctrine of home rule gives some cities greater local autonomy, and local governments actively lobby at both the national and state levels. Larger cities in Canada

³ This pattern (discussed in Bowman and Pagan0 1990; Wagenberg et al. 1990; and Watts 1990) is being experienced by other federal societies, sometimes leading to extreme tensions and dissolution as in Yugoslavia.

⁴ Chandler and Bakvis (1989) provide a penetrating analysis of the drawbacks of federalism and its exacerbation of policy fragmentation. See also Chapman (1990).

⁵ Nathan (1990) provides an exceptionally useful framework for analyzing the power relationships of national and regional entities. Throughout this article, the term "regional" denotes the first level of subnational governments in the two countries being discussed (i.e., provinces and states).

also exercise greater influence over their own affairs and national and provincial policy making.⁶

In both nations, regional governments have their own historical, social, and cultural identification, but again with some differences. Unlike Canada, a common American culture is shared in terms of language and, to a great extent, religion, but both nations are faced with greater multiculturalism because of post-World War II immigration and the presence of indigenous populations. Regionalism and sectionalism, particularly the economic kind, have continued playing an important role in both countries; state and provincial governments have their own political traditions of being more or less activist.⁷ Those entities with more activist traditions often generate policy innovations that may be adopted by the central government or other regional governments. Conversely, less activist traditions can lead to greater central government involvement via mandates or grants to ensure more uniform standards and services across all regional governments.

Major differences, however, are evident in regional government authority in the two areas that have the greatest impact on housing policies for the frail elderly: revenue powers, the degree to which regional governments can determine the kind and amounts of revenue they raise and how revenues are shared by the national and regional polities, and roles in central government affairs, the means and extent to which regional governments influence national policies and programs. The U.S. states levy taxes on various sources, but with considerable variation (e.g., some have no state income tax); in most instances, the types of taxes levied by the national and state governments are the same, but the national government can raise more extensive sums. Thus, federal-state tax relationships tend to be relatively autonomous. To promote national policy goals, grants are provided to state and local governments or to nonprofit and for-profit organizations.

By contrast, Canadian provinces are precluded from levying taxes on major sources of revenue (e.g., income, broad-based consumption). Based on negotiated agreements with the provinces, the

⁶ This includes major cities such as Toronto and Vancouver. See Leach (1981).

⁷ This issue is addressed by Lammers and Klingman (1984) relative to aging-related policy in the United States and more generally by Bickerton (1990), Dye (1990), and Leach (1981).

Table 1. An Overview: Federal Systems in Canada and the United States

Nathan's Criteria (1990)	Canada	United States
Legal powers	<p>Provinces with individual constitutions Sections 92 and 93 of British North America Act (1867) grant them authority over internal, domestic, and municipal affairs and ownership of natural resources</p> <p>Enumerated, residual powers to national government</p> <p>National government collects taxes for provinces by mutual agreement; some taxes (e.g., natural resources) earmarked for provinces</p> <p>Local governments levy property taxes; one-half of municipal revenue from provinces</p> <p>Equalization grants</p> <p>Provinces with authority over areas of education, civil law, health and welfare, property, and civil rights</p> <p>Fiscal power over municipalities yields great influence over predominantly (75%) urban population</p> <p>Concurrent powers with national government</p> <p>Strong regionalism of colonial history and economic differences: Atlantic and Ontario, Quebec (French), Prairie and Territories (resource-rich, rural), British Columbia (Pacific rim)</p> <p>Multiculturalism</p>	<p>Original states with own constitutions; wrote federal constitution (1789) ensuring states' rights to run their own governments</p> <p>Enumerated powers to national government</p> <p>Limits on activities of national and state governments</p> <p>Many of same kinds of taxes raised by national and state governments</p> <p>Local units levy property and municipal sales taxes</p> <p>Grants flow from state to local, from federal to state to local, from federal to local</p> <p>Block grants</p> <p>Tenth Amendment grants "reserved" powers to states</p> <p>State laws on health, social welfare, safety, morals, consumer protection</p> <p>Many concurrent powers with national government; some preempted by national government</p> <p>Thirteen colonies with British heritage</p> <p>Regional tensions based partly on economic differences</p> <p>Territorial consolidation completed in late 19th century</p> <p>Primary cultural identification was white Anglo-Saxon Protestant, now greater multiculturalism</p>
Revenue powers		
Functional area authority and responsibilities		
Historical, social, and cultural identification		

Table 1. An Overview: Federal Systems in Canada and the United States (continued)

Nathan's Criteria (1990)	Canada	United States
Role in the affairs of the central government	Intergovernmental consultation, semiformalized system of continuing meetings between provincial and federal authorities addressing concerns of federal and provincial governance; "executive-federalism"; advisory committee structures	U.S. Senate represents states Many programs involve joint action of all levels of government Some consultation, especially among states State officials lobbies Advisory Commission on Intergovernmental Relations acts as source of information
Power over local units	Power over municipalities is exclusive to provinces With urban areas' growth and increasing financial demands on provinces, local governments tend to function as administrative arms of provincial governments and influence provincial policies	Varies by state; home rule delegates state authority to municipal or local level, although final authority rests with states Local authorities may administer federal programs independently of states Local government officials lobbies

central government raises taxes on their behalf and then shares the resulting revenues with them—an example of interdependent relations. Provinces retain the power to raise revenue from several sources, including national health plan premiums; those provinces not raising the average federal per capita tax receive equalization payments from the central government. Nonprofit/community groups are funded to promote national goals.

In both nations, the regional governments want a bigger piece of the tax pie, largely because recent decentralizing trends have left them with greater responsibilities than they can fund themselves (Bowman and Pagano 1990; Burgess 1990). The states and provinces, in turn, seek to promote implementation of their own policies by local authorities and the nongovernmental sector. With localities this promotion may take the form of grants, a more cooperative mode of interaction, or of mandates, a more hierarchical relationship. With the nongovernmental sector, grants and subsidies are the preferred mechanism; regulatory powers may also be exercised.

Even greater differences exist in the regional government roles in shaping central government affairs. Thus far, Canada has eschewed formal representation of the ten provinces in the upper house of the national legislature.⁸ By contrast, the United States has opted for equal representation of the 50 states in the upper house of Congress, with senators often voting for their individual state interests, not as a bloc representing state-level concerns relative to national action.⁹ The maintenance of national-regional relationships is also very different. In Canada, the principle of “executive federalism” undergirds a system of periodic conferences of federal and state executives and of negotiated agreements requiring timely evaluation. Intergovernmental task forces are convened, often at the request of the provinces, to address such issues as long-term care. The parliamentary form of government and the relatively few regional governments encourage this type of exchange and bargaining. As in tax policy, the interdependent/cooperative model is dominant in Canada, exemplified by

⁸ A provision of the 1992 national referendum on a new constitution included this concept and has been regarded as one of the reasons for the failure of the referendum.

⁹ As Derthick (1992, 13–14) observes, the social, economic, and partisan differences that divide the states have ordinarily proved more powerful than their common status as governments in the federal system. Historically the states have had difficulty concerting action vis-à-vis the federal government.

the interprovincial cooperation required to make the equalization payments system workable.

The United States, however, has fewer formal mechanisms for negotiating federal-state relations, with a pattern of national preemption extending to areas previously acknowledged as state concerns.¹⁰ The U.S. Advisory Commission on Intergovernmental Relations established by Congress largely acts as a source of information for federal and state policy makers, rather than as a broker. State officials have developed patterns of interstate consultation through formal associations (e.g., the National Governors Association [NGA], the National Conference of State Legislatures) that often lobby at the national level. On occasion a more consultative model is used, as occurred with the NGA and former President Bush on education policy. States and localities can also resort to the courts and adversarial administrative procedures when national laws or federal regulations are deemed inimical to their interests. Federal courts have become more deeply engaged in supervising state and local functions, including public housing (Derthick 1992). Thus, the nature of U.S. federalism is generally characterized by a mix of autonomous and hierarchical relations, in contrast to the Canadian pattern of negotiated interdependence and autonomy.

Federalism and aging policy

The policy environment affecting the growing numbers of elderly in both nations is complex, given the involvement of three levels of government and the private (commercial, nonprofit, and voluntary) sector. Both countries are aging societies, but with important differences. At the beginning of this decade, the United States had more persons aged 65 and over: 31.5 million or 12.6 percent of all Americans, somewhat larger than the entire Canadian population of 27 million; 2.8 percent of all Americans were age 80 and over, the age group most likely to be frail. Canada had 3.1 million elderly or 11.5 percent of all Canadians, fewer than the number of older Californians; 2.4 percent were age 80 and over (U.S. Senate 1991).

Future projections indicate some changes in the relative positions of the two countries. In 2025, the aged in the United

¹⁰ Although this issue has been addressed by numerous writers, Zimmerman (1991) has developed an excellent framework for analyzing the nature of national dominance in intergovernmental relationships.

States will still outnumber those in Canada—59.7 million to 7.4 million; however, the elderly in Canada will increase by more than 140 percent compared with the 89 percent growth in older Americans. A higher proportion of persons in Canada will be aged 80 and over: 5.6 percent compared with 4.6 percent of all Americans (U.S. Senate 1991). These trends have led, in part, to expanded policy efforts for older Canadians and Americans and to the creation of special national agencies—the Ministry of Health and Welfare for Seniors in Canada and the U.S. Administration on Aging and the National Institute on Aging.

Policy efforts in both nations have focused on enhancing the income security of the elderly. In Canada, this is achieved via a tripartite federal approach: the Canada/Quebec Pension Plan, a contributory plan; means-tested programs, such as Old Age Security, the Guaranteed Income Supplement, and Spouses' Allowance; and tax relief programs, such as sales tax assistance for low-income households (Health and Welfare Canada 1991). These programs have successfully alleviated some poverty among Canadian elders. In 1989, 6 percent of aged families were poor, compared with 10 percent of non-aged Canadian families; for older singles the poverty rate was 38 percent, down from 62 percent in 1980. This high level of poverty among the older, single elderly is largely fueled by the greater rates (41 percent) of poverty among elderly women, compared with those (27 percent) for aged men (National Advisory Council on Aging 1991a).

In the United States, the figures are similar, but the effects of the federal Social Security program have significantly improved the poverty rates of older Americans. In 1989, their poverty rate was 11.4 percent compared with 12.8 percent for the total U.S. population. For aged families, the poverty rate was 6.6 percent; for unrelated persons, it was 22 percent, with higher rates (23.4 percent) for older women compared with older men (17.3 percent) (Ryscavage 1991).

Neither central government has sole responsibility for the aged, however.¹¹ It is shared with the regional governments, as exemplified by the six provinces that add to the federal means-tested programs with income security programs of their own or the

¹¹ See the National Advisory Council on Aging (1989, 1991b). The latter is a Canadian group that represents nearly all provinces. Its American counterpart, the Federal Council on Aging, does not attempt to represent the states.

Supplemental Security Income supplements (optional or mandatory) provided by all but two states. Regional policies are often driven by the numbers and proportions of the elderly within their respective jurisdictions (see table 2). Although some studies have shown that the proportion of elderly has little effect on state-level policy efforts for the aged,¹² their absolute numbers can affect own-source and intergovernmental funding and regional-level lobbying activity by older persons and their service providers. Specific regional-level agencies for the elderly have been created, reflecting the upswing in subnational aging policy, especially in housing for the elderly.

Federalism and suitable housing for the frail elderly

In the latter part of this century, particularly in the post-World War II years, the objectives of housing policies in many industrialized nations shifted from production (“bricks and mortar”) to social welfare concerns of quality, affordability, and accessibility by certain population groups (Brink 1990; Butler 1986; Hills et al. 1990; McGuire 1981). Because of higher poverty rates compared with other population groups, the aged were viewed as a special-needs group and often were major beneficiaries of national housing policies helping low-income households (Heidenheimer, Hecló, and Adams 1983).

With increasing numbers of much older people living longer and becoming more impaired in their ability to function, however, it is clear that the housing needs of this elderly subgroup have moved beyond affordability. These needs include housing that is more adaptive to reduced functioning, conducive to reducing social isolation, and capable of offering a range of supportive services.¹³ Suitable housing for frail elders, therefore, must focus on the production of appropriately designed or adapted low- and moderate-income housing promoting or sustaining optimal functioning and safety; on ensuring tenure through financial assistance and consumer protection; and on promoting a wide range of housing

¹² Lammers and Klingman (1984) have investigated this question in the United States. To the author’s knowledge, no such empirical analysis of the Canadian provinces has been conducted.

¹³ Brink (1988, 1990) and Pynoos (1990) make a good case for this need in Canada and the United States. See also Clapham and Smith (1990) for a more general commentary.

Table 2. The Elderly Population^a in Canada and the United States,
by Regional Governments: By Numbers^b and Percentages^c

	Canada (1986)		United States (1988)	
	Number	%	Number	%
Ontario	993	11.5	Highest six ^d	
Quebec	701	10.0	California	3,011
British Columbia	350	12.1	New York	2,328
Alberta	205	8.6	Florida	2,201
Manitoba	140	12.4	Pennsylvania	1,793
Saskatchewan	114	13.0	Texas	1,660
Nova Scotia	104	10.9	Illinois	1,421
New Brunswick	79	11.0	Lowest six ^d	
Newfoundland	50	8.8	North Dakota	90
Prince Edward Island	16	12.7	District of Columbia	77
Northwest Territory	1.4	2.8	Delaware	77
Yukon Territory	0.9	4.0	Vermont	66
			Wyoming	45
			Alaska	20
				3.8

Source: American Association of Retired Persons (1989), Canada Year Book (1988).

^a Age 65 and over.

^b In thousands.

^c Proportion of elderly in relation to total population of province or state.

^d "Highest" and "lowest" denote states with most or least numbers of elderly.

options between one's own home and institutional settings, with appropriate levels of care.

The required interweaving of three policy areas, housing, health, and social services—no simple task under any condition—is made more complex by the number of governments involved, more than 83,000 in the United States and more than 4,200 in Canada,¹⁴ and by the involvement of nongovernmental institutions, described below.

Housing policy for the aged

The effects of federalism on housing policies affecting the aged are described in table 3. Older Canadians and Americans have been major beneficiaries of general, non-age-specific central government policies designed to stimulate housing production and homeownership through macroeconomic (e.g., secondary mortgages or mortgage insurance) and/or tax policies; to provide income-tested rental assistance or housing allowances; and to develop publicly subsidized rental housing.

The U.S. government has been very active in the housing area, primarily through taxation, to promote homeownership; more than 70 percent of the elderly own their own homes, a proportion nearly matched in Canada (Brink 1988). Both central governments have provided incentives (subsidies or grants) to regional and local governments and the nonprofit sector to build and maintain low-income housing, especially for the elderly, and have also initiated or promoted demonstration projects that combine housing with services for the elderly. Both have also provided rental assistance and public housing programs as well as funding for home rehabilitation or weatherization programs for low-income households, all of which have been beneficial for the aged. For example, of the very low income U.S. households receiving federal rent subsidies, 24 percent are elderly, surpassed only by single-parent households (Turner 1989); 45 percent of public housing units are occupied by the elderly (U.S. Senate 1989). In Canada, elders comprise 45 percent of all recipients of rent supplements and 46 percent of public housing occupants (Brink 1992).

¹⁴ It should be noted, however, that the numbers of governments in the United States are inflated by special-purpose districts (e.g., mosquito abatement) and school districts that have very little to do directly with housing issues of the aged.

Table 3. **Federalism and Housing for the Aged in Canada and the United States**

	Canada	United States
National	<p>Aged are beneficiaries of federal housing programs—none specifically for the elderly</p> <p>Federal standards to measure housing needs, funding of research studies, design guidelines</p> <p>Subsidies for public housing operation, rent; some rehabilitation (loans)</p> <p>Phased out: public housing production</p> <p>Bilateral agreements with provinces</p> <p>Public mortgage insurance</p> <p>Nonprofit and cooperative housing program subsidies</p>	<p>Some programs specifically for older people; aged are major beneficiaries of public housing programs, homeownership</p> <p>National demonstration program of housing with services</p> <p>Funding for weatherization, for home modifications (minimal)</p> <p>Block grants for community development</p> <p>Secondary mortgage market to promote ownership, home equity conversions, granny flats</p> <p>Rental assistance (income-tested)</p> <p>Aging-in-place</p> <p>Tendency to age-segregated policies</p>
Regional (province; state)	<p>Aging-in-place, mainstreaming policies</p> <p>Cost share 25% of social housing operations</p> <p>Receive nonprofit program funds to own and manage social housing</p> <p>Can develop housing to supplement national programs</p> <p>Property tax rebates (all); housing allowances for aged (six); rehabilitation and repair programs (eight)</p> <p>Demonstration programs for granny flats</p> <p>Aging-in-place policy</p> <p>Provide subsidies to indigent for rent costs of nursing home care</p>	<p>Large interstate variation</p> <p>Eligible for national funding for affordable housing projects (aged included)</p> <p>Provide own-source funding for subsidized housing, home repairs, congregate housing</p> <p>Promotion of shared housing, some Elderly Cottage Housing Opportunity housing, home equity conversions, purpose-built housing</p> <p>Property tax relief preferences (age, income-tested)</p> <p>Many regulate retirement communities</p>

Table 3. Federalism and Housing for the Aged in Canada and the United States (continued)

	Canada	United States
Local	<p>Some have nonprofit housing corporations, receive funds to own and manage social housing</p> <p>Building codes, land use, zoning regulation</p> <p>Collect property taxes</p>	<p>Receive national funding for low-income housing projects (aged included), weatherization</p> <p>Collect property taxes</p> <p>Some provide incentives to private developers</p> <p>Building codes, land use, zoning regulation</p> <p>Some provide single resident occupancy (SRO) housing</p> <p>Require "linkage" by developers</p> <p>Regulate landlord-tenant relations</p>
For-profit	<p>Most housing built by Social housing financed by</p>	<p>Most housing built, financed by Development of specific types of housing: assisted living, continuing care retirement communities (age-segregated) for upper income</p> <p>Own, manage board and care</p>
Voluntary nonprofit	<p>Receive cooperative housing program funds to build or buy housing</p> <p>Some own and operate social housing</p> <p>Provide lion's share of new social housing units</p> <p>Receive tax credits for home modifications for persons with mobility problems</p> <p>Some operate homes for aged</p> <p>High levels (about 65 percent) of homeownership</p> <p>Little home equity conversion activity</p> <p>Pay monthly fee for housing aspect of nursing home</p> <p>Property tax relief</p>	<p>Some create, manage single-room occupancy housing</p> <p>Receive national, state subsidies, low-interest loans to build low-income housing for handicapped and aged</p> <p>Owners of low-income rental property receive subsidies to guarantee difference between market rental and tenant ability to pay</p> <p>High levels (about 70 percent) of homeownership</p> <p>Low home equity conversion activity</p> <p>Some vouchers</p> <p>Property tax relief</p>
Individuals/families		

In a less positive vein, both Canada and the United States withdrew from their previous active roles in public housing during the late 1970s and 1980s. Canada abandoned market stimulation programs, opting for supports for homeownership that required little public expenditure, for example, a capital gains tax exemption. The emphasis in public housing shifted from jointly built and managed federal-provincial projects for low-income tenants to socially mixed, privately financed housing (Brink 1992; Canada Mortgage and Housing Corporation 1991). Since the 1980s, cooperative housing and nonprofit housing programs, both of which were initiated in the 1960s have accounted for 80 percent of all new social housing (Hulchanski 1990). In 1992, however, the cooperative housing program was terminated, leaving only the nonprofit housing production and rent supplement programs intact, plus a Residential Rehabilitation Assistance Program that provides subsidized loans for low-income owners making housing changes that conform to health and safety standards. However, new funding for these programs has ended and funds already committed for expenditures were capped at \$2 million Canadian in 1993. A new federal program, Housing Adaptations for Seniors Living Independently, designed to pay for home modifications, will probably end in 1994 (Brink 1992, 1993 [personal communication]).

Similarly, the U.S. federal government role in the housing sector was dramatically curtailed in the past two decades. Low-income housing policy abandoned the previous emphasis on production and switched to an emphasis on tenant-based forms of assistance such as vouchers (Turner 1989). In 1990, however, a more proactive role was reassumed by passage of the National Affordable Housing Act (NAHA), the first major federal housing legislation in a decade. That legislation declared an official policy of “aging in place,” as has Canadian policy. Both nations are moving to develop elderly-specific housing or “supportive housing” tailored to the needs of the physically and mentally impaired aged. Less agreement exists between the two countries, however, as to whether age-segregated or age-integrated (“mainstream”) housing for the frail elderly is the better policy, with the United States favoring age-segregated housing.

Other differences should be noted. The Canadian national government has developed standards to measure housing need and guidelines for elderly housing, but there are no federal housing

programs¹⁵ exclusively for the elderly. Jointly operated federal-provincial social housing programs are the norm, usually based on negotiated agreements requiring cost-sharing (25 percent) by the provinces. Of approximately 630,000 units of social housing, about 310,000 are cost-shared. The national government also unilaterally administers social housing projects in some provinces to ensure that all Canadians have equal access to federal housing, regardless of a province's ability to pay (Brink 1992).

Since 1959, the U.S. government has developed age-specific housing projects, such as Section 202 housing, and a secondary mortgage market has recently been developed by Fannie Mae to promote home equity conversion mortgages (HECMs)¹⁶ and an Elderly Cottage Housing Opportunity (ECHO) program. Approximately 300,000 units of Section 202 housing were built with low-interest loans to nonprofit developers to provide housing for moderate-income elderly ineligible for public housing. These buildings were designed for independent older persons who, as they became more frail, were expected to relocate to other housing, such as board and care homes.¹⁷ No services were provided in U.S. Department of Housing and Urban Development (HUD) budgets to avoid developing old-age homes, a policy that generally discouraged federally funded, service-rich housing (Lawton, Moss, and Grimes 1985). In 1974 the program was retargeted to low-income households and linked to the Section 8 rental assistance program.

Unlike Canada, the U.S. government has not been proactive in establishing the legal framework and standards for the design and siting of residences for the aged or in conducting local housing market research; these activities are left to state or local authorities. Under NAHA and its successor legislation (the National Housing and Community Development Act), however, the federal government has emphasized supportive housing programs for the elderly. NAHA changes the Section 202 program to expand the

¹⁵ Similar to this action reported by Canada's National Advisory Council on Aging (1989) is a recommendation made by a presidential task force on aging in 1970 (President's Task Force on Aging 1970); however, it was never enacted.

¹⁶ A limited HECM demonstration program administered by HUD was a precursor of this program.

¹⁷ Board and care homes generally are privately owned, small group homes (3 to 10 residents) that provide laundry, housekeeping, meals, and help with bathing and similar activities.

supply of housing for the elderly and provide supportive services, that is, meals, health-related services, transportation, and house-keeping tailored to the needs of frail elders.¹⁸ NAHA also revises the existing Congregate Housing Services Program (CHSP), a national program serving 3,000 persons in 63 sites, allowing retrofitting of individual units and common areas to meet the needs of residents and accommodate supportive services. On-site service coordinators providing a continuum of care are also part of the new CHSP. A five-year demonstration program, Hope for Elderly Independence, tests the effectiveness of combining up to 1,500 Section 8 rental certificates with vouchers for nonmedical supportive services. Low-income, frail elderly recipients are not required to live in particular buildings to participate—an unusual “untying” of housing and services.

Although these new laws are a laudable blueprint for the development of supportive housing for limited numbers of the aged, there are problems. Several NAHA programs (e.g., HOME, which can be used for new construction, moderate and substantial rehabilitation, and tenant-based rental assistance, all of which could benefit the elderly) require 50 percent state and local government matches. Current bureaucratic obstacles to spending, lack of appropriations in the first year of operation, and the incapacity of many subnational jurisdictions to generate the necessary match have slowed NAHA’s implementation.

In both nations, activities of the regional governments are highly variable. Some are regulatory in nature (e.g., board and care in the United States). More focus on expanding housing options; for example, shared housing, ECHO housing, and programs for rehabilitation and weatherization in the United States. In both nations, these activities are often funded by regional own-source revenues.¹⁹ In Canada, sheltered housing, bifamily housing,²⁰ and garden suites (similar to ECHO housing) are the major options

¹⁸ Frail elders are defined as persons 62 years and older who are unable to perform at least three activities of daily living (ADLs) such as bathing, feeding, and toileting.

¹⁹ For a discussion of recent intergovernmental activities in housing for the elderly, as well as other related policy arenas, see Brink (1988), Lammers and Liebig (1990), and National Advisory Council on Aging (1991b).

²⁰ Sheltered housing, an English model, is a small group home with services and caretaking by a “housemother”; bifamily housing is the division of an existing house into two sections, each with its own street address, to ensure the availability of caregivers for the elderly person.

being promoted. Regional governments also actively promote greater local government and nonprofit sector involvement via joint ventures or incentives such as grants and loans. Canada's provinces, however, have generally played a more consistent role in housing for the elderly than the U.S. states. Six of ten provinces have their own rental assistance programs targeted to elderly households, and eight have home repair and renovation programs that enable aged homeowners to age in place rather than relocate.

Historically, the states have served primarily as a conduit for federal subsidies to the housing sector. After dramatic federal retrenchment in the 1980s, states attempted to fill the resulting gap. Direct state-funded programs nearly tripled; a total of 112 were developed in 40 states, with half of the programs created in Connecticut, Maryland, and Massachusetts (Turner 1989), and many of them targeted to the elderly. The recent fiscal problems of most states have resulted in many programs being curtailed or eliminated. Under the HOME program, 40 percent of funding is to be allocated to the 50 states, each of which is to receive a minimum of \$3 million. This may lead to more state-level activity in the future, if the required match can be made.

The roles of local governments in both nations are more consistent, particularly in their regulatory roles. Zoning, land use, and building codes are major municipal responsibilities that can often limit the establishment of low-cost accommodation for the aged. They can restrict innovations in the design of special housing that would materially enhance the functioning and psychological well-being of the frail elderly, despite the policy goals of regional or central governments. For example, in both countries, regional governments have attempted, often with limited success, to override local zoning restrictions precluding the construction of accessory apartments and ECHO housing on residential properties of family members/caregivers. Regulations restricting the numbers of unrelated individuals cohabiting have also stymied the development of small group homes and shared housing in residential areas. In addition, the not-in-my-back-yard phenomenon has blocked the establishment of mobile home parks, an affordable housing alternative for many elders.

Local government activity in housing production and maintenance for the aged is uneven. In the United States, many local governments have active municipal housing corporations and authorities or community development agencies; some have exercised "linkage" by requiring developers to include a specific number of low-income

units often targeted to the elderly. In Canada, local government participation is less frequent. In both nations, higher levels of local action are often induced by national housing subsidies, or by provincial government inducements in Canada and, to a lesser extent, by state government inducements in the United States.

In keeping with free market ideas, the commercial sector has been very important in housing production in both nations. Increasingly, especially in the United States, commercial developers are entering the market of age-specific housing for healthy and frail elders via continuing care retirement communities (CCRCs) or assisted living residences, primarily for upper income elderly.

An even greater reliance has been placed on the nonprofit sector to own and maintain low-income rental housing for the aged through direct subsidies, grants, and loans from national and/or regional governments. Aging-in-place has led some developers to participate more in linking services with existing housing or in modifying individual units or common spaces to better meet the changing needs of tenants over time.

It is clear that numerous Canadian and American aged have benefited from age-neutral national housing policies. These policies have been largely characterized by high levels of interdependency and cooperation among the three levels of government and the nongovernmental sector to promote homeownership and affordable housing through increased rental housing supply and assistance and, in the United States, through age-specific policies. The existence of “elderly housing” and perceptions in the United States (but not in Canada) that the elderly have garnered more than their fair share of publicly subsidized housing (see Khaduri and Nelson 1992) have led some to believe that housing problems for this population are “solved.” This, however, flies in the face of what we know about the needs of frail elders for supportive physical environments that sustain rather than challenge their diminished function (Lawton 1980), an area in which Canada seems to be exercising greater leadership. It also belies the need to merge health and social services policies with those of housing.

Health policy for the aged

As shown in table 4, significant differences exist between Canada and the United States in health policy affecting the elderly, in contrast to their similar patterns in housing. The United

States relies very heavily on the private sector for health care financing and increasingly on the national government for standard setting and regulation.²¹ The role of private insurance is distinct, as is the lack of a national health plan, *except* for Medicare acute-care coverage of the elderly and disabled financed by earmarked payroll taxes, beneficiary premiums, and federal tax revenues. A large proportion of the elderly purchase private insurance to supplement Medicare coverage (“Medigap”). Like Medicare, this rarely pays for much home health care. Regulatory standards for Medigap have been enacted at the national level and must be enforced by the states. Reduced Medicare payments for hospital and physician services have been enacted, placing a greater financial burden on the aged. A national means-tested health plan, Medicaid, jointly financed by the state and central governments, provides care for many poor of all ages.²¹

By contrast, Canada’s federally and provincially financed health care system provides universal coverage for conventional hospital and medical care, with all Canadians covered by the same provincial plan as their neighbors. This program of medically necessary services, including home health care, is administered by the provinces; some receive equalization payments from the central government to ensure that all Canadians, *regardless of age*, receive the same basic services. Private insurers may not sell supplementary coverage for publicly insured services; doctors essentially cannot charge patients anything more than the government’s fee schedule (Marmor 1991).

Both nations, however, emphasize nursing homes as a major component of health care for the elderly and the setting of national standards for nursing home care. (Although nursing homes are also a housing arrangement—a fact recognized by Canadian policies requiring individuals to pay for the “pure” housing cost—most of what is provided is health care.) Joint national-regional government financing is the norm, but with variations in the proportions paid. Another similarity is the growing emphasis on providing home or community nursing (especially in Canada) or home health care, rather than institutional care, partly to restrain costs. The U.S. Medicaid program pays for more than 40 percent of nursing home care. Medicare and private long-term care insurance pay very little; the balance is paid by elders and their families.

²¹ This policy area has generated increasingly greater intergovernmental tensions, as discussed by Hawkins (1989) and Zimmerman (1991), among others.

Table 4. Federalism and Health Services for the Aged in Canada and the United States

	Canada	United States
National	<p>Universal health insurance for medically necessary services</p> <p>Grants to provinces with equalization payments for poorer ones; set guidelines for provincial administration</p> <p>Capping of national support (38 percent)</p> <p>Extended Health Service Program does not cover nursing home care</p> <p>Little encouragement of nursing home construction</p> <p>Some funding for research</p> <p>Delivers services in territories and to veterans</p>	<p>National health insurance for aged, disabled—Medicare</p> <p>Health services for poor (including aged—joint funding with states (50 to 83 percent)—Medicaid; requires states to expand coverage</p> <p>Sets standards for states to administer (nursing homes, "Medigap" insurance, assessment)</p> <p>Funding for research, training</p> <p>Delivery of services: veterans, native Americans, and residents of territories</p>
Regional (province; state)	<p>Administer universal health program, including home health</p> <p>Many variations in long-term care: nursing home insurance in six; some cover drugs, eyeglasses, personal care homes; home care not tied to physician approval</p> <p>Negotiate limits on hospital budgets, doctor fees; some with nursing homes; regulate nursing homes; provide grants to nonprofit homes</p> <p>Some moving toward payroll taxes to supplant premiums</p>	<p>Medicaid-joint funding; waivers permit flexibility for noninstitutional care for the poor</p> <p>Own-source revenues for health and mental health, drug assistance</p> <p>Some assessment programs</p> <p>Regulation of hospitals, nursing homes, private long-term care insurance, licensing of professionals</p> <p>Few fund research; more fund training; state hospitals</p> <p>Must pay Medicare premiums for poor aged</p>
Local	<p>Receive grants for hospital care</p> <p>Not big role in health area except facilities zoning</p>	<p>Big delivery system, especially at the county level</p> <p>Zoning codes for health care facilities</p>

Table 4. Federalism and Health Services for the Aged in Canada and the United States (continued)

	Canada	United States
For-profit	<p>Minor private insurance industry</p> <p>Providers negotiate with provinces about fees</p> <p>Important roles as owners of nursing homes,</p>	<p>Big role for private insurance industry; employers as source of retiree health</p> <p>Private (for-profit) hospitals, doctors, home nursing; three-fourths of nursing hospitals homes are proprietary</p> <p>Fee for service medicine (few controls)</p> <p>Big role of organizations of doctors, hospitals, and nursing homes</p>
Voluntary nonprofit	<p>Some nursing homeownership</p> <p>Receive provincial grants for long-term care patients, for charges to pay for operating deficits</p> <p>Important source of donations, services delivery, hospital ownership</p> <p>Health organizations receive federal grants to enhance seniors' health</p>	<p>Role of religious organizations and other voluntary groups; nursing homes, hospitals</p> <p>Twenty percent of nursing homes are nonprofit-owned, -operated</p> <p>Important source of donations, free time for services delivery</p>
Individuals/families	<p>Payment of premiums for coverage-those unable to pay get assistance</p> <p>Permanent long-term care residents in hospitals may have to pay for meals</p>	<p>Pay Medicare premiums</p> <p>Purchase private insurance to supplement Medicare ("Medigap") for out-of-pocket costs</p>

In Canada, regional governments play major roles in financing and administering health care, accompanied by national government cofinancing and broad outlines for eligibility and administration. Acute and long-term care health costs are negotiated by the provinces with hospitals, nursing homes, and physicians. This pattern of provincial autonomy results in significant geographic variations in long-term care services and costs, also characteristic in the United States.²² Six of the ten provinces provide some nursing home insurance, whereas four states have cosponsored the sale of such insurance, largely due to the incentives provided by a private foundation.²³

The U.S. national government, however, has enacted several Medicaid program mandates, for instance, home health care for eligible persons. It also requires the states to pay Medicare premiums for the elderly poor. Mandates often inhibit innovations by tying state funds to federal requirements, lessening accountability to state citizens. They also significantly increase state costs for health care (Hutchison 1990). Federal waivers that allow states to use Medicaid funds for noninstitutional long-term care result in significant variation among the states in the types of services (e.g., pharmaceutical assistance) financed through the Medicaid program or their own-source revenues.

Canada and the United States also have some similarities. The national governments provide some health care services directly to veterans, indigenous populations, and persons residing in the territories. Local governments in both deliver some health care, but their role is greater in the United States, partly as an outgrowth of the deinstitutionalization movement of the 1960s and 1970s which resulted in a marked decrease in the number of state hospitals and mental hospitals.

The roles of the private, for-profit sector in the health area differ markedly in the two nations. American employers and private insurers play major financing roles. Although nursing home fees are subject to specific public reimbursement levels and at least a

²² Not only is this true of Canada (see Fletcher, Stone, and Tholl 1987; Health and Welfare Canada 1990; and Kane and Kane 19857, but it is also characteristic of several other countries, as described by Tilly and Stucki (1991).

²³ The Robert Wood Johnson Foundation has been a promoter of numerous health and housing demonstration projects affecting the elderly, such as supportive services in publicly assisted housing and the promotion of long-term care insurance.

third or more of nursing homes are proprietarily owned in both nations, for-profit ownership in the United States is larger. Provider associations in both nations play major roles in negotiating fees and in political and lobbying activities.

The voluntary sectors in the two nations play similar roles in the provision of both institutional and home nursing services, but the proportions of nonprofit ownership are generally smaller than those found in the proprietary sector. In Canada, there is a pattern of direct subsidies and grants to nonprofit groups, including nursing homes and corporations run by community boards, to deliver health and social services. Subsidies to such organizations in the United States are usually provided indirectly through tax exemptions from all governmental levels.

When it comes to health care and suitable housing for frail elders, the dominant model in both countries has been the nursing home, or some variant such as the U.S. CCRC, in which health and housing are a package. The increasingly stringent restrictions on Medicare reimbursement for home health care or home modifications have also made it more necessary for many older Americans to opt for institutional care. By contrast, all older Canadians are covered for home health under the national plan, and publicly supported community nursing is available for the more ambulatory elderly. This separation of health care from the place of residence is more conducive to aging-in-place for frail Canadians.

Of equal contrast is the framework of federal-state relations for health care of the aged. As described above, the U.S. model is generally characterized by hierarchical and coercive relations. Even the Medicaid waivers program and state experiments within it have often been adversarial in nature, as exemplified by the recent experience of Oregon in setting up a priority listing of medical treatments to be covered. In Canada, far more is left to the regional governments, which play major roles in policy making, financing, and administering universal health care, based on federal-provincial and provincial-provider negotiations. Recent capping of central government support, however, may change this balance, with the provinces having to make forced choices.

In both nations, however, because certain health care issues are delegated, large variations occur in long-term care health services. High levels of decentralization to subnational governments

and the nongovernmental sector generally lead to considerable geographic diversity. Essentially neither country has a universal, comprehensive long-term care system, as revealed by even more diffuse patterns of social services.

Social services for the aged

An overview of how responsibilities for nonmedical home- and community-based services (e.g., personal care, transportation, recreation) are allocated is provided in table 5. The social service needs of the aged are an important issue in both countries; in-home services for the frail elderly are being emphasized, largely due to the high costs of institutional care. As with health care, the U.S. trend is to “package” services with housing (e.g., assisted living); in Canada, the movement is toward “untying” care from housing.²⁴

In both nations, national government activity falls into two broad areas: the funding and delivery of services to veterans and indigenous populations, the latter often through subsidies or grants to nonprofit associations representing them; and the provision of incentives to other public and private entities. Federal funds are allocated to induce regional governments to provide social services to needy persons, regardless of age, via block grants: the Canadian Assistance Program (CAP) and the Social Services Block Grant (SSBG) in the United States. These grants set broad guidelines permitting high levels of discretion as to which services are to be offered, and to whom. Under CAB, the central government pays 50 percent of the cost of providing social assistance to persons in need to provinces and 50 percent of certain costs of providing welfare services, especially residential programs, to those likely to become in need. CAB tends to benefit most those provinces that can best afford to implement programs and can also establish cost-sharing agreements with municipalities (Kane and Kane 1985, 1989). In addition, regional governments may and often do finance with their own resources a wide range of basic social services for persons needing them; user charges, based on income, may be levied (Brink 1992).

Under the SSBG program, states receive funds based on their population for services, such as homemaker, chore, and personal

²⁴ See Health and Welfare Canada (1990). A similar trend appears to be occurring in other nations, such as Australia and the Scandinavian countries.

Table 5. Federalism and Social Services for the Aged in Canada and the United States

	Canada	United States
National	<p>Greater emphasis on in-home care Joint funding with provinces for the needy (CAP)* Capped block grants to provinces: general assistance, emergency services for aged and disabled in community Joint committee with provinces on long-term care services Specific responsibility for veterans (low-income), Indians, territories</p>	<p>More emphasis on in-home, community based care Tax exemptions for nonprofit organizations Block grants (means-tested) to states for social services (not age-specific) Older Americans Act funds to states (population-based; aged 60 and over) National demonstration programs Specific responsibility for veterans (low-income), native Americans, territories</p>
Regional (province; state)	<p>Joint funding with national government for the needy (CAP) Administer programs, determine level of cost sharing Some have demonstration projects to foster volunteer, community efforts Some regulate for-profit service delivery Some provide home care, case management adult day care; support meals-on-wheels All provide homemaker services Some administer CAP programs Some fund part of home support services Some receive provincial grants to deliver meal services, day care</p>	<p>Broad discretion about services offered, recipient groups Some experiments in support for nonprofit, family caregivers Can add own-source funding, create new types of programs (e.g., day care) Provide funds to voluntary, nonprofit groups to deliver social services Consumer protection regulation</p>
Local		<p>Receive federal funding via state agencies, state funding Delivery of social welfare programs, special services (e.g., guardianship) Regulation of facilities</p>

Table 5. Federalism and Social Services for the Aged in Canada and the United States (continued)

	Canada	United States
For-profit	Growing market, but still minor	Growing market, especially private care managers
Voluntary nonprofit	Old-age groups can receive grants for community programs Support for family caregivers (respite)	Some corporate sponsorship of community-based services Provision of services often on a contractual basis, own funding Support of community-based services (e.g., foundations, United Way)
Families/friends	Provide 85 to 90 percent of domiciliary care Can receive provincial payment on "exception" basis, some respite	Support for family caregivers (respite) Provide 80 percent of care Receive limited tax deductions for caregiving, direct-pay experiments, some respite

* CAP = Canadian Assistance Program.

care.²⁵ States can engage local governments or nonprofit agencies in service delivery. Additionally, a non-means-tested program—the Older Americans Act—is targeted specifically to persons aged 60 and over. The U.S. Administration on Aging provides federal funds to state agencies on aging for allocation to local agencies that are expected to broker and coordinate local services for the elderly, especially the socially or economically disadvantaged. The levels of federal funding, given the numbers of elderly, are very modest. Many states also fund services such as adult day care and respite care using their own revenues.

In both nations, the responsibility of regional governments in the realm of social services is more fluid than in the health area. They are far less likely to be involved in direct service delivery and administration, preferring to provide federal or own-source funding and other incentives to local governments or voluntary organizations to discharge those tasks. This leads to geographic differences in the types of services provided, as does the initiation of demonstration projects and the participation or lack of it by local governments, charitable organizations, and consumer groups. Still, Canadian provinces tend to be more uniform—all provide homemaker services, and six of ten provinces support meals-on-wheels programs with public funds. Local governments also receive direct or indirect funding from the two central governments for particular services; large cities may fund their own programs, further adding to geographic differences in the ‘availability of and access to services.

The U.S. commercial provision of social services for the aged is more highly developed, especially for-profit case management for frail, usually affluent elders. There is also a tradition of corporate and foundation charitable activities. In both nations, however, the voluntary sector is heavily relied on to provide social services, using public sector funding and resources raised by volunteers’ own efforts and resulting in even greater variability. Even more important is the role of families and friends volunteers who provide between 80 and 90 percent of the social support, transportation, and personal care services that enhance the well-being of frail elders. Both public and private sector policies and programs are being developed that directly

²⁵ For a recent study of the allocation of services to the elderly under the SSBG program, see Brown (1990).

assist these crucial caregivers, but most are quite limited.²⁶ Policy makers generally are reluctant to provide direct payments to family caregivers; however, limited programs have been developed by two provinces and 37 states.²⁷ Voluntary and nonprofit groups provide caregiver training and respite care programs, sometimes with government subsidies. Seven of ten Canadian provinces subsidize respite care, requiring only minimal copayments, in contrast to 18 of their U.S. counterparts.

Public and private sector responsibilities for social services assisting frail elderly Americans and Canadians can be seen as very similar, as is their net result. The slow development of formal services is the weakest link in suitable housing for frail elders; what does exist receives inadequate funding from either set of central and regional governments. Although both nations emphasize coordinated systems of care, competing agencies at all levels of government render the integration of services with housing difficult, if not impossible. In addition, place of residence and geographic location often determine the availability of care services. Finally, neither country has developed sound public policies that support informal caregivers (families and friends).

A step in the right direction, however, has been undertaken by Canada through a national-provincial long-term care task force. Initiated by the provinces, this undertaking identified existing services in the provinces and territories and ways in which they can be better integrated at the individual level and delivered in residential settings (Health and Welfare Canada 1990). U.S. policy makers have not developed a similar approach as a guide for future action.

Conclusions

The examination of suitable housing for the frail elderly in these two federal societies requires an assessment of both policy outcomes and process.

²⁶ For a discussion of these policies in Canada and the United States, especially at the regional government level, see Liebig (1993).

²⁷ An extensive discussion of public policies and programs in the United States may be found in Linsk et al. (1992).

Policy outcomes

The older populations of Canada and the United States have generally benefited from housing policies in terms of homeownership and access to publicly subsidized housing programs. The persistent rates of poverty among the elderly, especially for the very old, minorities, and older women (particularly in Canada), and the current and projected numbers of elders aged 75 and over, however, indicate the need for continued production of low- and moderate-income housing, especially rental housing. Recent U.S. housing legislation could play an important role, but the dependence on subnational activity and matching funds may result in an inadequate supply of new housing for the elderly. Canada, by contrast, seems to have abandoned the joint federal-provincial production of housing at a time when the numbers of its very oldest, poorest population are escalating. Age-specific housing policies may require reactivated public sector solutions to fill the gaps in housing for much older, poorer Canadians for whom market approaches are not likely to succeed now or in the future.

When it comes to housing outcomes for the *frail* aged, the past picture has been less positive. For a long time, supportive environments and services were not viewed as a proper housing policy concern for any age group, let alone the elderly. This has changed, however, and both nations are beginning to move toward housing policies that are more specific to frail elders. This shift is spurred largely by policy makers' growing recognition that this subgroup of the elderly has special needs that go well beyond affordable shelter, necessitating focusing on the physical environment of housing and long-term care medical and social services.

Appropriately modified housing or purpose-built "universal design" housing sustaining and supporting the diminished function of frail elders is not available on a wide scale in either country and is not likely to be in the foreseeable future. Canadian policies for an age-specific, nationwide home modifications program, however, provide some hope that this necessary component of housing policy for the frail elderly will become a permanent reality. By contrast, current U.S. policy authorizes the funding of a few demonstration programs, rather than a nationwide approach. At this juncture, the extent to which subnational jurisdictions are proposing to undertake these projects is not well known. Further, we have little information concerning the use of reverse mortgages for home modifications by the elderly or the extent

and effects of retrofitting Section 202 housing and other housing on the frail aged. Clearly, this is an area ripe for research.

Besides physically supportive environments, the services component of housing for the frail elderly is a major issue for U.S. and Canadian policy makers. Although both countries are grappling with ways to increase nonmedical long-term care services, Canada's inclusion of home health care as part of its national health plan is in contrast to the limited provision under Medicare in the United States. The current U.S. health care system exacerbates geographic differences in care availability and does not provide the basic home health care coverage that is a critical component of suitable housing for the frail elderly. In addition, federal mandates to the states are not helpful in creating the type of universal health plan that would be conducive to providing suitable housing for the frail elderly. Although U.S. private long-term care insurance now includes coverage for home care, it is still a very limited market. Possible changes in the U.S. approach to financing health care are likely to be extended over several years, and it is not clear what long-term care medical and social services may be included or what roles sub-national governments will be playing in the implementation of health care reform.

The lack of an adequate level of social services for an ever-growing number of frail older persons is likely to be a continuing problem for both nations. Unlike Canada, current U.S. policy continues to tie services to the place of residence, whether in a nursing home, board and care housing, or assisted living and CCRCs. Thus, frail elders are often required by circumstances to move their residence to obtain supportive services. In addition, local governments in the U.S. are struggling to provide these social services, but are severely constrained by a lack of revenues.

Whether Canada will be able to provide an adequate level of services that are "unbundled" remains to be seen. This long-term care conundrum is being faced by most of the industrialized world, and more research is needed on the types of model solutions other nations are developing.

Policy process

The effects of federal policy processes in Canada and the United States also require further scrutiny. The three policy domains affecting suitable housing for the aged in these two federal

societies show marked similarities in how governmental and non-governmental responsibilities are distributed, except health policy. Recent decentralization has already necessitated redefinitions of intergovernmental relations in policy making, financing, and administration, and, therefore, of accountability in all policy areas, including those affecting frail elders. Policies are not solely *national* or central government policies; they are *federal* and shared among central and regional and, increasingly, local governments. U.S. and Canadian subnational governments are now called upon to play more active roles in housing, health, and social services for the frail elderly. Many local governments in Canada, however, have not been accustomed to activist roles and may benefit from analyzing the roles of their U.S. counterparts in delivering a wide range of services, including housing.

In both countries, growing demands on regional and local governments are often not accompanied by increased fiscal capacity. The greater capacity of both central governments to raise revenues will require them to continue playing major roles in setting national policy guidelines and financing programs for the frail elderly, particularly in housing production.

The central and regional governments in both nations have been able to use their fiscal capacities, singly and jointly, to leverage additional resources to finance housing, health, and social services that meet the needs of the frail aged and other vulnerable populations. The fiscal clout of the central governments, through various kinds of grants and subsidies, has clearly influenced subnational policy making and enhanced the likelihood of a “national” approach to meeting societal needs. The Canadian lesson, however, is that greater fiscal power of the central government can be accompanied by high levels of regional government discretion, flexibility, and effectiveness. In addition, specifically designed central government equalization payments can be used to ensure a basic “floor” of services.* Overall, the Canadian pattern of negotiated and autonomous federal-regional relationships seems to have permitted greater strides toward providing suitable housing for the frail elderly and actively developing policies that allow older persons to age in place.

²⁸ Alice Rivlin in *Reviving the American Dream*, a book focused on federalism in the United States, suggests a similar mechanism, “common shared taxes.” See also Rivlin (1992).

The shifts to greater decentralization in both nations provide more opportunities for increased interdependent policy making and “nationwide” policies in which the regional governments are more active and consistent partners. Although increased joint policy making may obscure previous understandings about which level of government is accountable, the overall result may be enhanced accountability of the entire public sector to its citizens, particularly if the process of reaching joint agreements is clearly articulated.

Canada’s “executive” federalism structures allow greater ease and clarity in tracking accountability in joint policy making and increase the likelihood that administration will be more consensual and therefore more effective. The parliamentary form of government, which combines the executive and legislative functions, and the relatively small number of regional governments promote this type of administrative exchange and bargaining. The U.S. doctrine of separated powers and the greater number of states make the development of this type of approach to intergovernmental relations far more problematic. Some U.S. precedents do exist, however, which form the basis for more interaction of this kind: intrastate Councils of Governments, interstate agreements, and recent joint agenda setting by the President and the National Governors Association in educational policy. Unless the United States develops some type of federal-state dialogue similar to that involved in Canada’s system of executive federalism, it is unlikely to make much progress in coordinating housing and long-term care services for the frail elderly.

For the foreseeable future, decentralization is likely to continue in both countries, emphasizing regional and/or local administrative problem solving and discretion, adding private sector participation, and operating within a framework of national standards and guidelines. Although it can be argued that this approach leads to geographic inequities, a strong case can also be made for its capacity to generate innovative and appropriate responses in keeping with the particular cultural, historical, and political preferences of different regions, communities, and ethnic and racial groups in countries like Canada and the United States. The targeting of resources can be achieved better at the regional and local levels, where direct political participation of all kinds is more likely. Uniformity is not the same as accountability; rather, the responsiveness of governments to the differing circumstances and preferences of their citizens is accountability of the highest order.

To meet the needs of frail elders for suitable housing, it may be far more important to ensure basic equity via an *average* or *core* level of services across all regional boundaries, through visible, articulated equalization strategies and negotiated policy making in the areas of health and human services. At the same time, this would allow for differences in the political willingness and fiscal capacities of regional and local governments to ensure the provision of additional services that are responsive to the diversity of different groups of vulnerable persons, such as the aged, within their jurisdictions. Community resource and needs assessments that are jointly financed by national and regional governments and accompanied by joint incentives (e.g., funding, technical assistance) to stimulate the public and private production of services may be far more conducive to serving the needs of the highly diverse frail elderly wherever they reside.

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