

An Overview of Home and Continuing Care in Canada

Presented by:
Marcus J. Hollander, PhD

Presented to:
Innovations in Home Care: A Public Policy
Perspective (Simon Fraser University
Gerontology Research Centre and the
Institute for Research on Public Policy

May 16, 2012

Hollander Analytical Services Ltd.
300 - 895 Fort Street
Victoria, BC V8W 1H7



Tel: (250) 384-2776
Fax: (250) 389-0105
E-Mail: marcus@hollanderanalytical.com

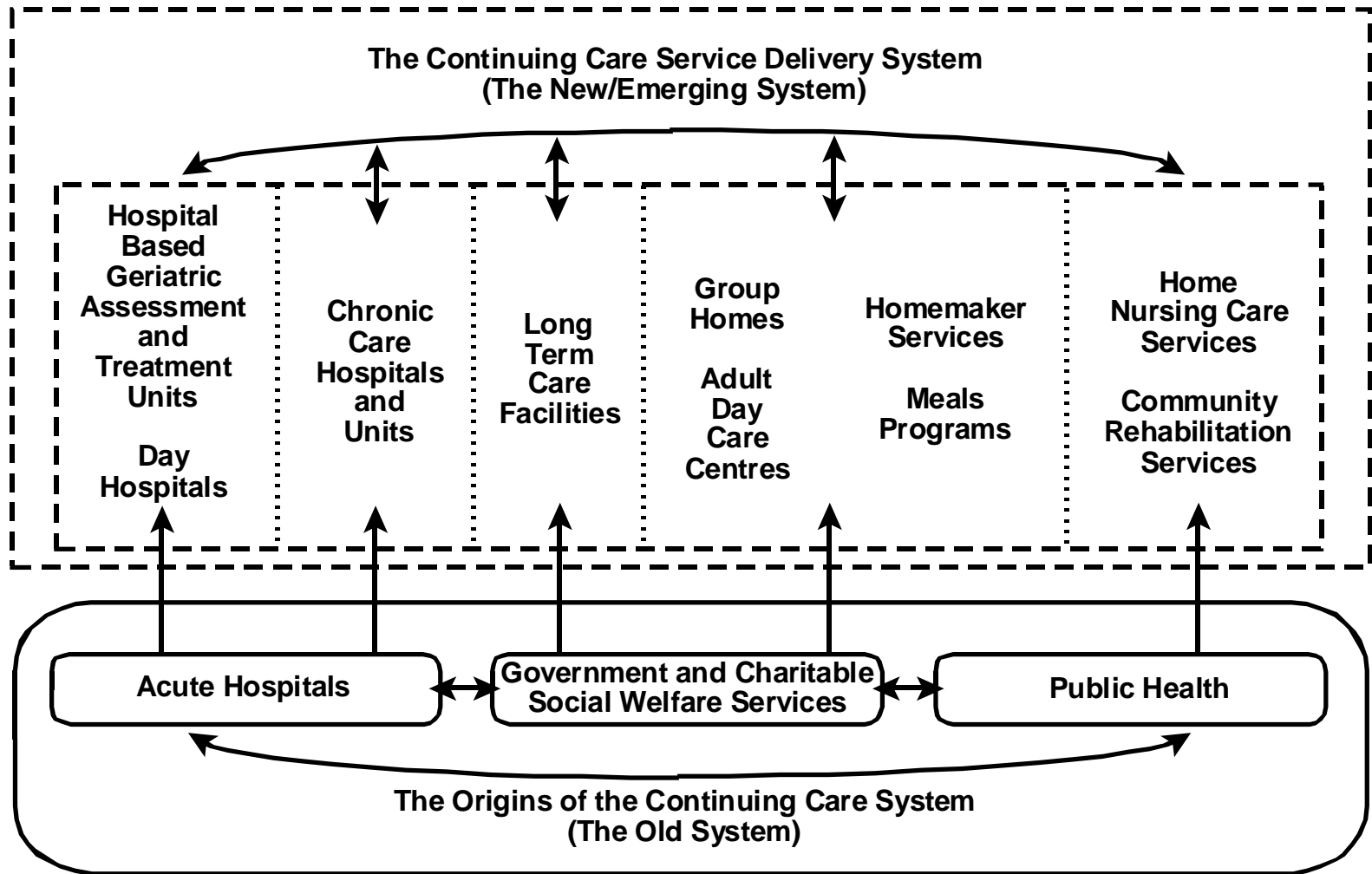
The Three Functions of Home Care

1. The **Maintenance and Preventive Function**, which serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently, and in many cases preventing health and functional breakdowns, and eventual institutionalization.
2. The **Long Term Care Substitution Function**, where home care meets the needs of people who would otherwise require institutionalization.
3. The **Acute Care Substitution Function**, where home care meets the needs of people who would otherwise have to remain in, or enter, acute care facilities.

The Role of Home Care and Home Support

- Home care (including home support) can be seen as a valuable service in its own right that is worthy of additional support. However, in isolation, more support usually results in add on costs.
- In addition to being a stand alone service, home care can also be a vehicle, within an integrated system of care, to enhance value for money in our health care system through substitutions of lower cost care, for higher cost care, with equivalent or better outcomes.

The Emergence of the Continuing Care System



A Short History of Home and Continuing Care in Canada

- Home Care Nursing services have been available since the establishment of the Victorian Order of Nurses in 1897.
- Continuing care started in the mid 1970s in Manitoba and an integrated system of care was developed in BC between 1978 and 1983.
- In the 1970s, Québec developed a system of primary care health centres which included home care, other provinces maintained a separation between home care and residential care.
- By the early 1990s some 7 provinces had, at various points in time, one person responsible for the equivalent of a provincial continuing care service delivery system. There was also a Federal/Provincial/Territorial Sub-Committee on Continuing Care which functioned from the mid-1980s to the early 1990s and included both home and residential care representatives.

A Short History (cont'd)

- Continuing care has been in decline since the mid-1990s
- The F/P/T Sub-Committee on Continuing Care was disbanded in 1992, as part of a larger F/P/T committee restructuring
- Continuing care is no longer recognized as a major pillar of the Canadian Health Care System.
- The 2004 Health Accord focused on home care, not continuing care.
- Data are only collected and presented on some components of continuing care:
 - Thus there is no national data on continuing care services and expenditures *per se*.
 - Thus policy makers can not see how big and relevant continuing care is.

Regionalization and Primary Care

- Regionalization moved responsibility for service delivery from Ministries of Health to Regional Health Authorities in the 1990s. More recently Ontario and Québec have developed integrated health networks.
- In the regions, Continuing Care was combined with other services, or splintered into its component parts.
- Formal provincial systems of continuing care were disbanded and were replaced by units focusing on broad policy and monitoring.
- There was a concerted policy focus on primary care beginning in the mid-1990s.

Previous System

Hospitals	Primary Care	Continuing Care (including home care)	Drugs	Population and Public Health	Other Services (mental health, Ambulance, etc.)
-----------	--------------	---------------------------------------	-------	------------------------------	---

Current System (National Policy Focus)

Hospitals	Primary Care	Drugs	Population and Public Health	Other Services (long term residential care, home care, palliative care, respite care, etc.)
-----------	--------------	-------	------------------------------	---

- Continuing Care was, and would still be today if a system existed, the third largest component of public health expenditures after hospitals and primary care and, as such, deserves a greater policy focus.

British Columbia Ministry of Finance and Corporate Relations. (1992). *Estimates; Fiscal year ending March 31, 1993*. Victoria, BC: Crown Publications; Hollander, M.J., Miller, J.A., MacAdam, M., Chappell, N., & Pedlar, D. (2009) Increasing value for money in the Canadian healthcare system: New findings and the case for integrated care for seniors. *Healthcare Quarterly*, 12 (1), 38-47.

The Conundrum of Non-Professional Home Support Services

- People with ongoing care needs due to functional deficits clearly have “health” problems and require “medically necessary” care. However, the “medically necessary” care services they require to maximize independence and minimize their rate of deterioration are, in large part, non-professional home support services. This does not seem to be recognized in the current policy discourse.
- Home support is a low cost alternative to residential care and hospital care for both the preventive and substitution functions of home care.

Hollander, M.J., Chappell, N.L., Prince, M., & Shaprio, E. (2007). Providing care and support for an aging population: Briefing notes on key policy issues. *Healthcare Quarterly*, 10 (3), 34-45.

Comparative Costs

Per Person Average Costs of Care Before and After Cuts for Health Units With and Without Cuts

		Period			
		Year Prior to Cuts (\$)	First Year After Cuts (\$)	Second Year After Cuts (\$)	Third Year After Cuts (\$)
All Costs	Cuts	5,252	6,688	9,654	11,903
	No Cuts	4,535	5,963	6,771	7,808
Net Difference					\$3,478

Source: Hollander, M.J. (2001). *Evaluation of the Maintenance and Preventive Model of Home Care*. Victoria: Hollander Analytical Services Ltd.

- A recent study by Markle-Reid also found that modest amounts of home support services may reduce hospital and LTC facility costs.

Source: Markle-Reid, M., Browne, G., Weir, R., Gafni, A., Roberts, J., & Henderson, S. (2008). Seniors at risk: The association between the six-month use of publicly funded home support services and quality of life and use of health services for older people. *Canadian Journal on Aging*, 27 (2), 207-224.

Comparative Cost Analysis in 2000/2001 Dollars Including Out-of-Pocket Expenses and Caregiver Time Valued at Replacement Wages

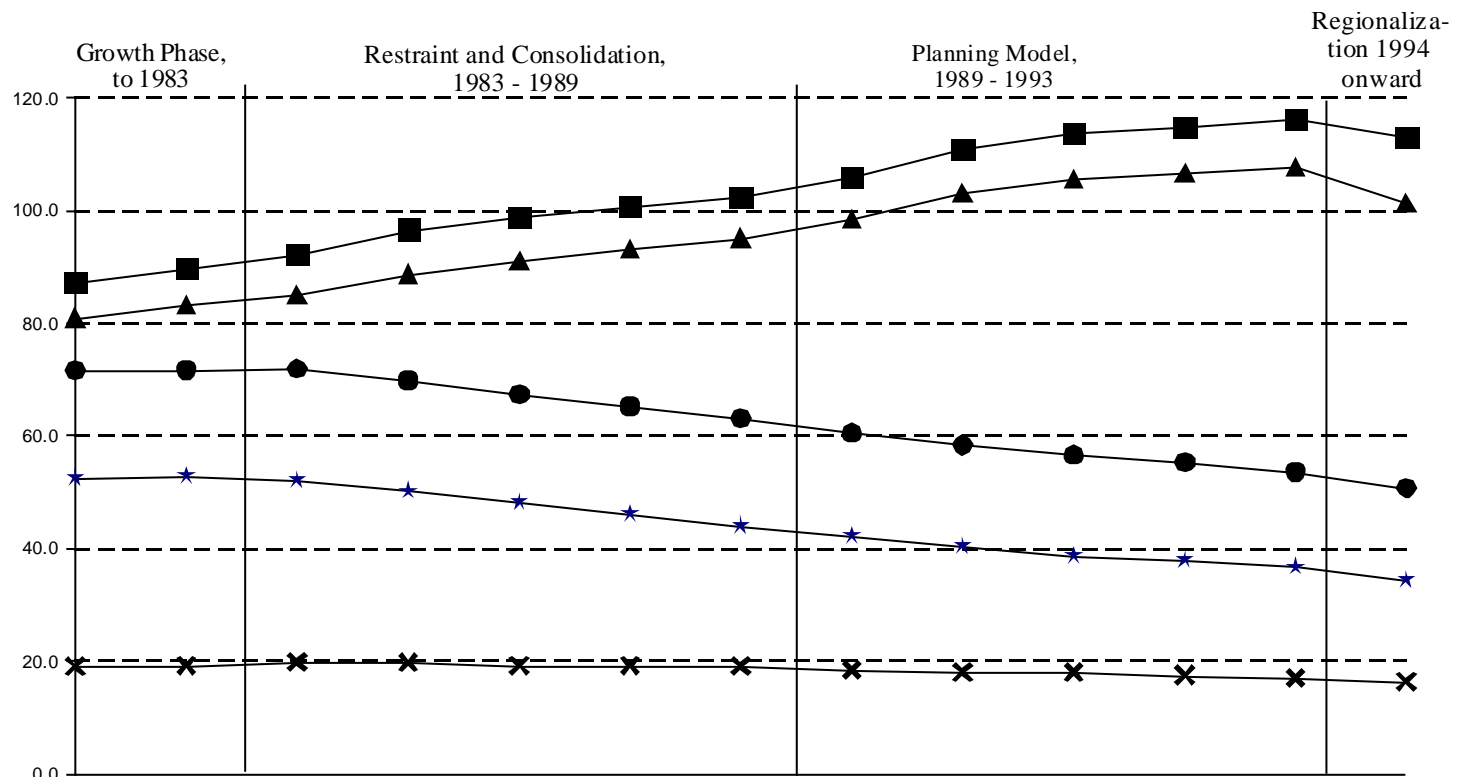
Level of Care	Victoria		Whippeg	
	Community (\$)	Facility (\$)	Community (\$)	Facility (\$)
Level A Slightly Independent	19,759	39,255	NA	NA
Level B Slightly Independent	30,975	45,964	27,313	47,618
Level C Slightly Dependent	31,848	53,848	29,094	49,207
Level D Slightly Dependent	58,619	66,310	32,275	45,637
Level E Largely Dependent	NA	NA	35,114	50,560

Source: Chappell, N.L., Havens, B., Hollander, M.J., Miller, J.A., and McWilliam, C. (2004). Comparative costs of home care and residential care. *The Gerontologist*, 44, 389-400.

Even If Home Care Is Cost-Effective, Is There Any Evidence That Savings Can Be Obtained In The Real World?

- Yes, this was demonstrated by the BC Planning and Resource Allocation Model developed in 1989. There was a significant shift of clientele from residential care to home care, while the overall utilization rate remained relatively constant.
- It is believed similar opportunities for cost-effective substitutions still exist. This is certainly the case based on VAC data.
- Thus, home care, in an integrated system of care, has the potential to increase the overall value for money of our health care system.

Major Phases In The Utilization Of Home Care & Residential Care

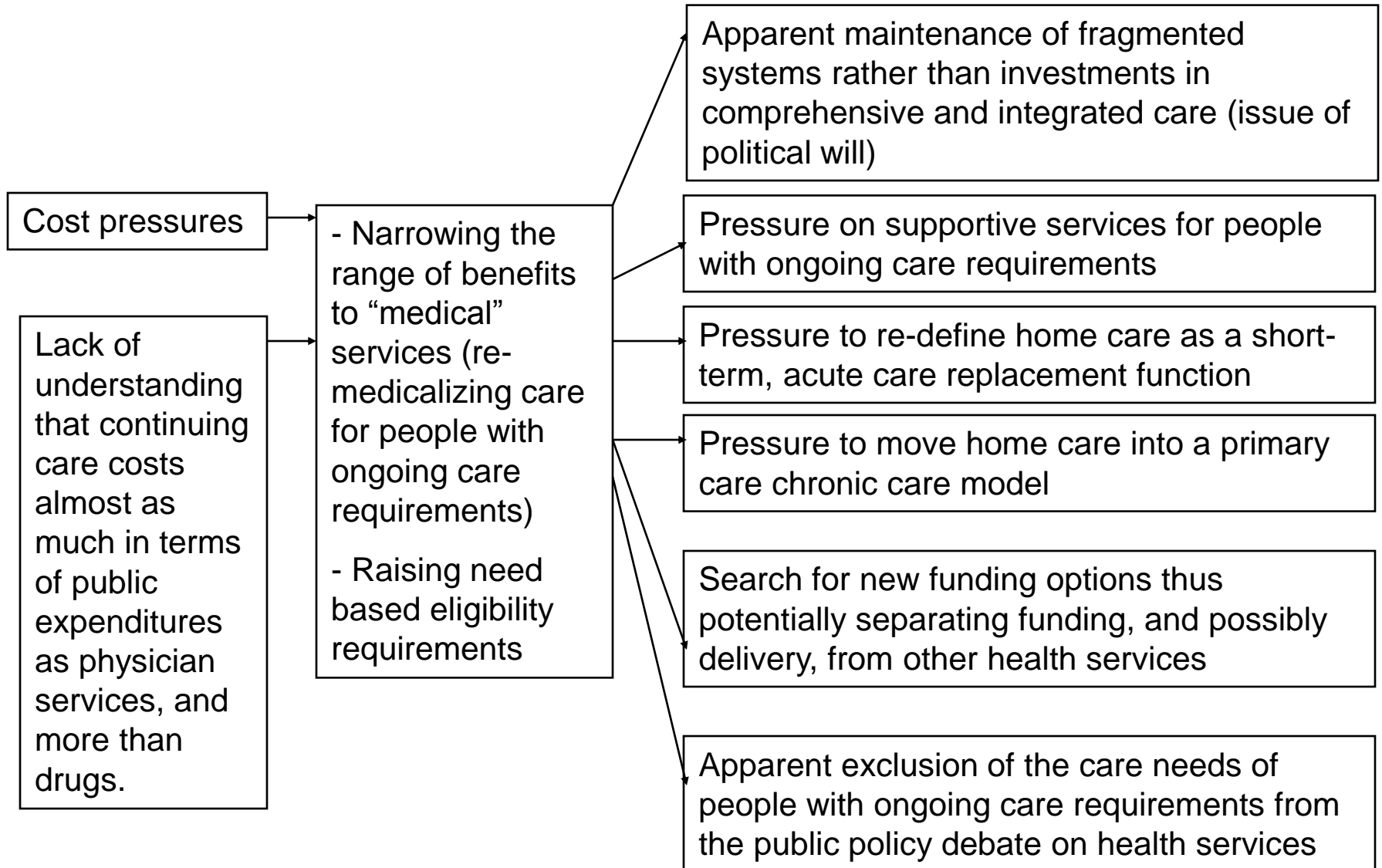


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
⑤ Community	87.2	89.5	92	96.5	98.7	100.7	102.4	105.8	110.8	113.8	114.8	116.2	113
⑩ Homemakers	80.9	83.1	84.9	88.7	90.9	93.3	95.1	98.4	103	105.5	106.5	107.6	101.2
⑨ Residential	71.5	71.6	71.7	69.7	67.2	65.1	63	60.4	58.2	56.5	55.2	53.5	50.7
⌘ LTC Facilities	52.5	52.7	52	50.1	48.1	46.1	44	42.1	40.3	38.6	37.8	36.7	34.4
⚡ EC Hospital	18.9	19.1	19.7	19.6	19.1	19.1	19	18.3	17.9	17.9	17.4	16.9	16.3

Utilization rates per 1,000 population aged 65 and over by fiscal year and type of care.
Fiscal year 1983 is for the period April 1, 1982 to March 31, 1983.

Source: Hollander, M.J., & Chappell, N.L. (2007). A Comparative Analysis of Costs to Government for Home Care and Long Term Residential Care Services, Standardized for Client Care Needs. *Canadian Journal on Aging*. 26 (SUPPL. 1), 149-161.

Current Canadian Trends in Policy on Home and Continuing Care



Current Status of Home Care

- Two approaches, split about evenly across jurisdictions
 - Assistance with ADLs only
 - Assistance with IADLs and ADLs
- Also, split about evenly are provinces that income test and charge user fees for home support and those like Manitoba which do not. Nursing and PT/OT have no user fees.
- Organization of service systems are in flux and many jurisdictions such as Alberta and Nova Scotia are conducting major reviews.

Most Common Home Care Services

- The most common home care services at the present time, across Canada, are as follows:
 - Case Management
 - Information/Referral Services
 - In-Home Nursing Care
 - Home/Community Rehabilitation (PT/OT)
 - Home Support Services/Homemakers/Care Aids/Attendants
 - Day Care/Day Support
 - Community Respite Care
 - Community Palliative Care
 - Technical Aids, Equipment and Supplies
 - Self-Managed Attendant Services

Most Common Home Support Services

- The most common home support services at the present time, across Canada, are as follows:
 - Bathing
 - Dressing
 - Grooming and Toileting
 - Mobilization
 - Lifts and Transfers
 - Safety Maintenance - Clean-up
 - Safety Maintenance - Laundry
 - Safety Maintenance - Meal Preparation
 - Cueing
 - Nutrition
 - Delegated Nursing Tasks
 - Delegated Rehabilitation Tasks

Conclusion: Key Policy Challenges/Choices for Home Care

- Who should be eligible for home care in terms of level of need, the full range of people or only intermediate to high care needs clients?
- Who should pay for what in terms of user fees?
- What is an appropriate integrated system of which home care and home support should be a part, continuing care or primary care?
- What kind of case management should we have, system level or home/community based?
- What constitutes sustainable funding?