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Home Care in Canada: Passing the Buck

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Cet article offre une vue d'ensemble de la demande exercée au Canada en soins à domicile, met en évidence les postulats en matière de politiques sur la santé qui ont donné lieu à la promotion des soins de santé à domicile, et évalue les rôles actuels des secteurs privé et public dans le financement de ces soins. Des variations interprovinciales importantes en matière de coûts par habitant pour des soins à domicile et les inégalités potentielles en ce qui a trait à l'accès à ces soins constituent des problématiques qui doivent être résolues par les gouvernements provinciaux. Un consensus doit être établi quant aux services médicalement et socialement nécessaires qui sont réglementés par des normes pancanadiennes, et ce peu importe le contexte dans lequel ces services sont sollicités, reçus et dispensés. L'élaboration et l'application de normes pancanadiennes relativement aux soins à domicile qui s'ajouteraient aux principes énoncés dans la Loi canadienne sur la santé constituerait une mesure pertinente permettant de s'assurer de la capacité du système de santé canadien à relever les défis de ce nouveau millénaire.

This paper provides an overview of Canadian home-care utilization, highlights the health-policy assumptions that have resulted in an increasing reliance on in-home services, and assesses the current roles of the private and public sectors in the financing of home care. Significant interprovincial variations in per capita home-care expenditures and potential inequalities in access to home care call for resolution by federal and provincial governments. There is a need for consensus with respect to medically and socially necessary services that are subject to national standards, irrespective of the setting in which services are sought, received, and delivered. The development and enforcement of national home-care standards that complement the principles of the Canada Health Act would be a useful first step in ensuring that the Canadian health-care system is ready to confront the challenges of the new millennium.

Introduction

The funding, organization, and delivery of home-care services have become prominent health-policy issues in Canada. In the last 25 years, the growth of public home-care expenditures has outpaced that of other health expenditures, yet home care accounts for only 5% of total health

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spending. Many factors account for this growth in home-care spending, including expanded eligibility, increased accessibility, technological advances, system restructuring, and demographic changes. However, a key is the common belief that significant public-sector savings may be realized by redirecting care away from institutions and towards the community (Hollander, 1994; Jackson, 1994; Jacobs, Hall, Henderson, & Nichols, 1995).

Shifts in responsibility for caregiving and for the financing of home care are the focus of this paper. First, health-policy changes that have resulted in an increasing reliance on in-home services are highlighted, with calls for evidence to direct and support these changes. Second, current and projected home-care utilization patterns are discussed. Home-care expenditures and shifts in the financing of home-care services are reviewed. Finally, recommendations are made for more equitable access to these services.

Health-Policy Shifts: Assumptions and Gaps in Knowledge

One of the major social changes of the last quarter century has been a shift in the setting for health-care delivery away from institutions. Policy development and system restructuring are continuing with very little evidence that what we are doing is right. Moreover, assumptions about the benefits of home and community care have taken on the status of conventional wisdom.

Restructuring has moved many types of health care, for people of all ages, into the home. It has shifted the emphasis from institutional care to home care, provided by an array of caregivers, including family and friends. The Canada Health Act (CHA), from its inception in 1984, has privileged care provided by physicians and all care and services provided in hospitals. However, in the last 16 years the share of total health expenditures covered under the principles of the CHA — that is, expenditures on hospitals and physicians — fell from 57% to 45.5% of total spending (Canadian Institute for Health Information, 1999). Thus, the CHA applies to the minority of health spending. While most provinces have chosen to publicly fund components of home care, shifts in the setting of care have opened the door for a major reallocation of health costs from the public to the private sphere, thereby eroding a hallmark of Canadian identity, the health-care system. Key policy issues that have arisen include: determining the base level of public coverage, the extent of cost-sharing (i.e., public with co-payment, private payment), and the role of the private sector in service delivery.

Policies advocating the provision of health and social services in the homes of Canadians have been supported with three commonly held assumptions. First, it is believed that people want to assume substantially greater responsibility for health-care delivered at home; want to be discharged from acute care early; want to remain in the community rather than reside in long-term-care facilities; and have family and friends willing and able to provide informal care. However, there is considerable concern about the potential responsibilities and costs that will be shouldered by family members and friends. Moreover, the advent of the "sandwich generation" — those responsible for both children and elderly parents — raises doubts about whether assumptions regarding the supply of informal care are appropriate for the new millennium (Keating, Fast, Frederick, Cranswick, & Perrier, 1999).

Second, it is assumed that Canadian housing and employment circumstances permit the safe shift of effective care to the home. Generally speaking, even the finest contemporary homes are not designed to facilitate the long-term provision of care and may be a sub-optimal environment both for clients and for in-home providers of informal and formal care. Complex and technically sophisticated care is being provided in the home now, but we do not know whether family members have the resources and amenities to cope safely with the changes. Moreover, while evidence demonstrates that women play the predominant caregiving roles, changes in patterns of labour-force participation and other competing demands on time raise questions about whether these supply conditions will persist.

The final commonly held assumption is that equal or better care at a lower cost will result from shifting care from institutions to the home. Although there are few empirical studies evaluating the costs and benefits of home supports, a report released by Saskatchewan's Health Services Utilization and Research Commission states that seniors receiving preventive home care were 50% *more* likely to lose their independence or die than those not receiving any services. In addition, average total costs for recipients of preventive home care were about *triple* the average health costs for non-recipients. In comparison, residents of seniors' housing were 63% *less* likely to lose their independence and 40% *less* likely to die than other Saskatchewan seniors. Residents of seniors' housing have about the same total health costs as non-residents (Health Services Utilization and Research Commission, 2000). Reviews of the international literature and reviews conducted for the Health Services Restructuring Commission of the province of Ontario (Coyte & Young, 1997b; Coyte, Young, & DeBoer, 1997; Health Services Restructuring Commission, 1997) found very little compelling evidence to support the

cost-saving assertions for home care (Health and Welfare Canada, 1990; Parr, 1996; Price Waterhouse, 1989), and few of the studies reviewed were directly applicable to Canada. Essentially, the research to date has been of limited quality (Parr) and has yielded diverse cost and outcome estimates (Hughes et al., 1997).

Thus, while home-care expenditures have risen, this increase has occurred without compelling evidence of cost-effectiveness (Health Canada, 1992; Parr, 1996; Price Waterhouse, 1989). Health managers, providers, and policy-makers have been frustrated by the lack of data concerning the costs and consequences of in-home services (Health and Welfare Canada, 1990; Jacobs et al., 1995; Parr; Price Waterhouse; Richardson, 1990). Little is known about the impact of home care on health and lifestyle, or the extent to which the burden of care has shifted from institutions to patients, families, and community agencies (Parr). Moreover, there is a growing perception that unless these services are targeted to specific client groups they will not represent a cost-effective alternative to institutional care (Weissert, 1985, 1991; Weissert & Cready, 1989; Weissert, Wan, Livieratos, & Pellegrino, 1980). Two recently heralded studies concerning the use of home care following acute hospitalizations (Saskatchewan Health Services Utilization and Research Commission, 1998) and as an alternative to facility-based long-term care (Hollander, 1999) suggest that home care may lower costs without adversely affecting the health of Canadians. While neither study used randomization to identify the unique contribution of home-care services, both suggest that cost savings might result from modifications to health-service delivery and organization. However, before any radical change to the health-care system is undertaken, evidence is needed to confirm these preliminary results.

In addition, while various organizational and financing reforms, such as the introduction of Community Care Access Centres in Ontario (Ministry of Health, 1996), have been designed to promote more equitable access to services and to lower costs through increased competition, their impact has yet to be determined. The home-care sector is labour-intensive; hence a lower cost entails lower wages and fewer benefits for nurses and other personnel, which may erode staff morale and adversely affect the quality of care. These observations have recently been echoed by the Registered Nurses Association of Ontario (1999), which highlighted the fact that competition results in the delegation of tasks to unregulated providers and reduces the number of in-home visits to care recipients. Clearly, more evaluation is required to identify the consequences of competition in order to inform health management and policy development.

Current and Projected Home-Care Utilization and Expenditures

Currently, an array of home-care agencies and providers participate in the delivery of a complex range of health and social services to a variety of clients (Coyte & Young, 1997a; Health Canada, 1999; Stewart & Lund, 1990). The range of services includes nursing, social work, physiotherapy, audiology, occupational therapy, meal delivery, and personal support. While most clients receive these services to prevent or retard the deterioration of health and to help them to maintain their independence, others receive rehabilitation services following, or in lieu of, hospitalization. It is useful to characterize access to in-home services in terms of two dimensions: the propensity to use home care (i.e., population-based rates of utilization); and, once home care is assured, the intensity (or the number and range) of in-home services received.

Differential access to services has been associated with the gender, age, and regional location of the client. In Ontario in 1995, the most recent year for which client-specific data are available, 261,635 clients received at least one provincially funded home-care service. The majority (60.1%) of clients were women. Although close to 50% of men receiving services were under 65 years of age, only 35% of women were in that age group. Almost 20% of male clients were under 20 years of age, while fewer than 10% of female clients were in that age category. Figure 1 depicts rates of home-care utilization per 1,000 population by age and gender. While the number of clients under 65 years of age is small, their rate of utilization is low (under 2%) compared to persons over 65. Women have 20% higher rates of utilization than men. The fact that utilization rates increase with age and are higher for women could reflect the needs of the elderly and persons living alone, who may have limited access to informal care.

Figure 2 shows the intensity of home-care utilization by age and gender. While average annual provincial home-care expenditures per client are substantial, at $2,736, total expenditures for clients under 20 years of age are approximately 60% of the provincial average. In contrast, the intensity of utilization by clients over 85 years is more than 20% greater than the provincial average. Hence, intensity of home-care use increases with age and is higher for women over 45 years.

Indications of intraprovincial variations in home-care utilization were first reported in Canada by Ontario's Health Services Restructuring Commission (Coyte & Young, 1997a; Coyte et al., 1997; Health Services Restructuring Commission, 1997) and later in three publications (Coyte & Axcell, 1998; Coyte & Young, 1999; Young, Coyte, Jaglal, DeBoer, & Naylor, 1999). These variations concerned the use of home-care services

Figure 1 *Home-Care Utilization Rates by Age and Gender in Ontario, 1995*

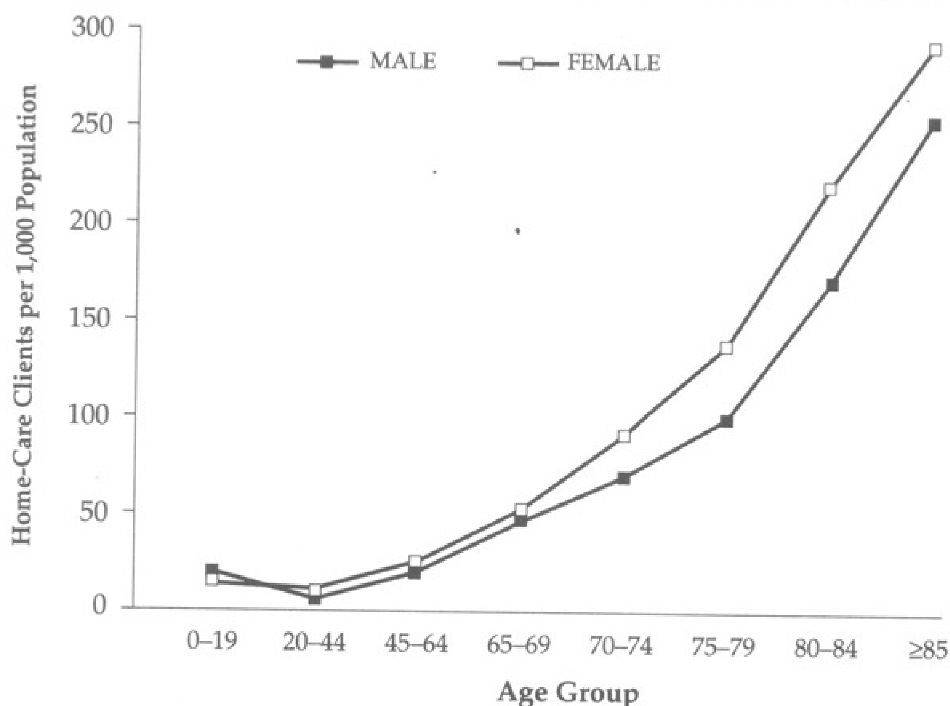
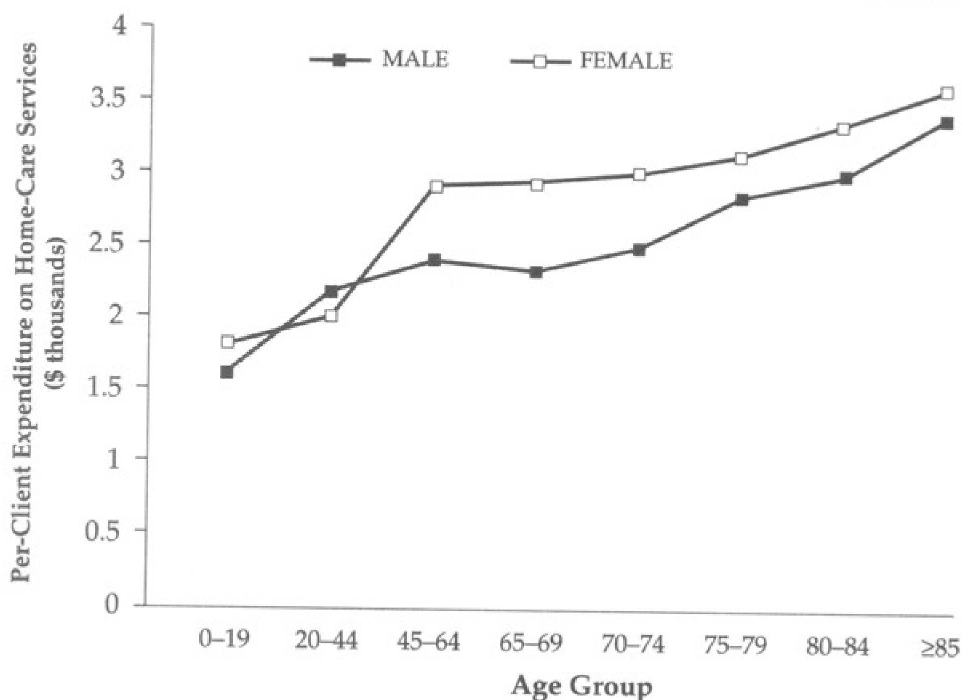


Figure 2 *Intensity of Home-Care Utilization by Age and Gender in Ontario, 1995*



following hospitalization. Irrespective of the methods used to measure variations, there were moderate to substantial regional variations even after adjusting for the composition of the population (Coyte & Axcell; Coyte & Young, 1997b, 1999; Coyte et al., 1997; Health Services Restructuring Commission; Young et al.). While the use of home-care services follows a similar pattern of variation as that reported for many health-care services (Coyte & Young, 1999; Coyte et al., 1997; Kenney, 1993), more information is required to track the extent of such variation in order to assess its determinants and to measure the resulting consequences for Canadians.

Home-Care Expenditures: Variations and Sources

Between 1975 and 1992, the annual growth rate for home-care expenditures was almost double that for total health spending (19.9% vs. 10.8%). Since 1992, home-care expenditures have risen at threefold the rate for other health spending (9.0% vs. 2.2%). Despite such dramatic growth, less than 5% of national spending was directed to home care in 1997. Further, there are wide interprovincial variations in home-care expenditures. Although on average Canada devoted $69 per capita to home care in 1997, spending in New Brunswick, Newfoundland, Ontario, and Manitoba was almost threefold that in Quebec and Prince Edward Island (see Table 1). These variations persist even after adjusting for the composition of the population.

Table 1 *Interprovincial Public Home-Care Expenditures per Capita, 1997*

Newfoundland	$92.25
Prince Edward Island	$34.26
Nova Scotia	$79.94
New Brunswick	$94.52
Quebec	$37.36
Ontario	$91.08
Manitoba	$90.50
Saskatchewan	$68.71
Alberta	$52.45
British Columbia	$62.06
Canada	**$69.20**

Source: Health Canada (1998).

At least five factors account for this wide interprovincial variation in home-care spending. First, there are variations in the level of total spending on health care, with per capita spending in Manitoba and Ontario almost 25% greater than that in Quebec (Canadian Institute for Health Information, 1999). Such variations affect the means available to allocate scarce provincial funds to all sectors of health care, including home care. Second, there are variations in the emphasis on the home as a setting for health and supportive care. In some provinces, community clinics and geriatric day centres are used more extensively than home care. Third, variations in the composition of the population, the availability of community supports, and social context influence the need for home care. Fourth, due to variations in the pace and extent of health-system restructuring, provinces are at different stages in the transition to home and community services. Finally, since home-care expenditures are defined as the sum of the number of services provided and the cost of each, some interprovincial variation may be attributable to each component of total spending.

If we distinguish between expenditures covered by the CHA, comprising hospitals and physician services, and those not covered, such as home care, it is clear that the share of private health financing has increased (see Table 2). While in 1975 the private sector accounted for 23.6% of total health spending, in 1999 it accounted for 30.4%. More than 80% of the growth in the private share is attributable to passive privatization, or cost shifting by government, the remainder being attributable to expanding markets and active privatization. Although there is a lack of robust information concerning the extent of private financing for home care, two surveys of household expenditures warrant consideration. A survey conducted by Price Waterhouse Coopers ("Home health care," 1999; PricewaterhouseCoopers Health Care Group, 1999) concluded, based on responses from over 2,000 Canadians, that 25% of home-care clients have average monthly out-of-pocket expenses of $407, and an additional $138 for prescription drugs. These expenditures represent almost 15% of average annual public home-care expenditures per client in Ontario. In addition, home-care clients recently discharged from hospital spent approximately $200 per week privately securing home-care services and supplies. A survey conducted by the privately owned home-care provider We Care Health Services ("How would you pay for home care?," 1999) estimated, based on responses from 33 of its 58 offices across Canada, that home-care clients incurred 24.5% of the cost of their nursing services and 59.3% of the cost of other support services. Average weekly out-of-pocket expenditures were estimated to be $283. While efforts may

Table 2 *Public-Private Financing of Various Categories of Health Expenditure*

		CHA Expenditures		Non-CHA Expenditures		Total
Public	1975	$7,009.3m	(74.9%)	$2,351.6m	(25.1%)	$9,360.9m
	1999	$36,852.8m	(61.6%)	$22,983.4m	(38.4%)	$59,836.2m
Growth rate p.a.		7.2%		10.0%		8.0%
Private	1975	$344.9m	(11.9%)	$2,554.3m	(88.1%)	$2,899.2m
	1999	$2,332.3m	(8.9%)	$23,844.6m	(91.1%)	$26,176.9m
Growth rate p.a.		8.3%		9.8%		9.6%
Total	1975	$7,354.2m	(60.0%)	$4,905.9m	(40.0%)	$12,260.1m
	1999	$39,185.1m	(45.6%)	$46,828.0m	(54.4%)	$86,013.1m
Growth rate p.a.		7.2%		9.9%		8.5%
Private share	1975	4.7%		52.1%		23.6%
	1999	6.0%		50.9%		30.4%

Note: CHA Expenditures refers to expenditures on hospitals and physicians. Non-CHA Expenditures refers to all others.

Source: Canadian Institute for Health Information (1999).

be required to ensure the reliability of these estimates, the results highlight the extent of private home-care financing.

In order to more precisely determine the extent of private home-care costs, data provided by three national in-home service providers (Comcare Health Services, Victorian Order of Nurses for Canada, and We Care Health Services) were reviewed. While there was some variation in the revenue share among organizations, and more dramatic regional variation, about 80% of each organization's total revenue was derived from provincial or federal government sources. If this share was maintained across all home-care provider organizations, in 1997 private financing of home-care services exceeded $500 million and total (public and private) home-care expenditures were approximately $2,620 million.

Future demographic changes are expected to have a profound effect on home-care expenditures. Based on Statistics Canada (2000) projections regarding population growth and the age-gender composition of Canadian society, home-care expenditures are expected to increase by almost 80% between 1999 and 2026. The magnitude of the effect of these changes is enormous, with the home-care share of total health spending expected to reach double digits by the year 2026.

Equitable Access to Home-Care Services in Canada

There are significant and potentially troubling variations in the funding, availability, accessibility, and quality of home care throughout Canada. These variations have sparked recommendations that the federal government revise and extend public insurance to ensure that all residents of Canada, irrespective of geographic location, have the benefit of equivalent levels of publicly insured home services. Such federal incursion into areas of provincial jurisdiction would require consensus on the entitlement, scope, and allocation of services. This would involve agreement on the terms and conditions of public insurance, such as the range of insured services (social/medical), the duration of coverage (acute/chronic), and the settings in which the services are provided. Of equal importance would be consensus on an array of financial concerns, including mechanisms to ensure equitable access, the scale of deductibles, the size of co-payments, the level and means by which service providers are reimbursed, and determinants of cost-effectiveness.

One way to achieve equitable access would be to identify and develop a "standard basket of goods," thus ensuring that all provinces and territories receive funding for the same range of in-home services. Ontario may be used as the standard for these calculations (Coyte, Hall, & Croxford, in press). This should not be taken to imply that the current level of home-care expenditures in Ontario and their allocation across alternative home-care providers are optimal.[1] However, the province is useful as a baseline for two reasons. First, data are available on patterns of home-care use and unit costs by age and gender in Ontario. Second, the province is in the upper range of per capita home-care expenditures. Hence, the data provide a baseline for comparison and an estimate of the increase in public home-care financing needed to ensure equitable access.

Table 3 illustrates actual and projected home-care expenditures in 1997 for all Canadian provinces and territories. The projections are based on three ingredients: the demographic composition of each region (Statistics Canada, 1998); the relative intensity of home-care expenditures by age and gender in Ontario; and per capita expenditure on insured in-home services in Ontario. The funding variance measures the (percentage) increase in expenditures needed to ensure that all Canadians have

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[1] The choice of Ontario would raise concerns if higher funding for home care were reflective of a policy decision to favour home care over hospital care. However, there is a paucity of evidence to support this contention: first, interprovincial per capita home-care spending is invariant to per capita hospital expenditures; and second, 1997 per capita hospital expenditures for Ontario ($750) were not significantly different from those for Canada ($766).

Table 3 *Actual and Projected Public Home-Care Expenditures in Canada and in the Provinces and Territories, 1997*

	Actual ($ millions)	Projected Population-Based Funding ($ millions)	Funding Variance (%) (Projected – Actual) x 100 / Actual
Newfoundland	51.991	47.488	-8.7
Prince Edward Island	4.701	13.885	195.7
Nova Scotia	75.777	93.326	23.1
New Brunswick	72.026	73.202	1.6
Quebec	277.198	677.452	144.4
Ontario	1,038.929	1,038.929	0.0
Manitoba	103.640	117.587	13.5
Saskatchewan	70.327	112.150	59.4
Alberta	149.318	223.730	49.8
British Columbia	244.113	373.793	53.1
Yukon	1.427	1.452	1.8
Northwest Territories	6.528	2.707	-58.5
Canada	**2,095.975**	**2,775.551**	**32.4**

Source: Health Canada (1998).

levels of funding for insured in-home services equivalent to Ontario residents. A negative variance, such as that reported for Newfoundland, indicates that current levels of public funding are more than adequate to guarantee services equivalent to those available in Ontario. A positive variance indicates that current funding is lower than Ontario's.

Given the wide variation in home-care funding in Canada, it is not surprising to find substantial shortfalls. Funding in both Prince Edward Island and Quebec is less than 50% of that required to ensure equivalence with Ontario. Even in Alberta, British Columbia, and Saskatchewan, funding would need to be increased by approximately 50% to match Ontario levels.

The estimates provided in Table 3 suggest that an increase in home-care funding of almost $700 million is required to ensure that all residents of Canada have insured home services equivalent to those currently

available in Ontario. While this is an increase of more than 30% in public home-care expenditures, it represents an increase of only 1.3% in total public health expenditures and an increase of only 0.9% in all (public and private) health expenditures.

Of course, implicit in these projections is the belief that uniform access to home-care funding, irrespective of region, is appropriate; that national standards should be developed outlining the range of publicly insured home-care services; that common eligibility conditions should be determined; and that common servicing plans should be drawn up once eligibility is determined. While it is a relatively straightforward matter to increase home-care funding, it is much more difficult to obtain agreement on the range of services that should be insured and to determine the precise terms and conditions of public insurance. Until these issues are squarely addressed at the national level, it is unlikely that progress will be made on a national home-care program.

Conclusions

The tidal wave that has changed the Canadian health-care landscape over the last two decades has come to rest upon the shores of the home- and community-care sector. This turn of events has had an enormous impact on care recipients, their families and friends, and in-home service providers. The future age structure, health profile, and geographic distribution of the population, coupled with reductions in the supply of informal care, will result in increased pressure to fund professional home-care services.

The federal government has an important role to play in highlighting and addressing interprovincial variations in home-care funding, by introducing and enforcing national standards. Such standards should include many of the principles that support services privileged under the CHA. They should also outline the terms and conditions of public insurance, including eligibility, servicing plans, and cost-sharing arrangements. Finally, national consensus must be reached on the range of medically (and socially) necessary services subject to these standards, irrespective of the setting in which they are sought, received, and delivered, in order for Canadians to achieve optimal care in the 21st century.

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