An Appropriate and Cost-Effective Health Care System for an Ageing Society

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For: Aging Research in Newfoundland and Labrador: Achievements and Prospects, Corner Brook, Nfld., Sept., 2012
The Starting Point

• Aging of the Baby Boomers
• Concern: providing care
  : bankrupting the system
  Stems from increasing longevity with declining health
Number of children aged 14 and under and of people aged 65 and over
Canada, 1921 to 2011

Sources: Statistics Canada, censuses of population, 1921 to 2011.
Some facts:

• Old age – mainly chronic conditions & functional disability
• The older we are, the worse it gets
• By definition, no cure
• Known subpopulations at risk (poor, socially isolated, etc.)
• Subjective & overall well-being high
• 98% have family/friends they feel close to.
• Despite geographical mobility >85% of OA live near at least 1 child.

That is: Not all older adults require care; not all that do, require long-term or extensive care; >75 require more care than younger elderly
Care

• Family & friends are the first resort for care and the mainstay of care
• Family & friends provide 75% - 85% of personal care to OA.
• Care from family & friends constitutes 70% of costs related to home care.
When Baby Boomers are Elderly?

• Greater proportions of couples
• More with surviving children
(Gaymu, Keefe, Carriere)
• Greater numbers of more childless
• More complex chronic conditions
• More complex families
• More siblings
• Future arrangements unknown
• OA prefer to live in the community; this is unlikely to change
• No evidence that family and friends can do more than they do now
• Most with care needs can remain in the community with social support and proper formal care.

• One of the strongest predictors of institutionalization is lack of social support.

• For OA to remain in the community caregivers often need support to continue.
Supporting Caregivers

• No national policy on caregivers
• Support falls to each province (Manitoba recently passed a caregiver act)
• Typically limited respite services available
• Several countries do more: Denmark, Finland, Australia
• Many Can. recommendations: Can. Centre for Elder Law, B.C. Law Institute, Senate Comm. on Aging, CCC, etc.
A Key Question:

• Do families provide less care when formal services are available?
• International research says no:
  - Informal care usually substitutes for formal, not the other way around; esp. for home care, not physician services (Bolin, et al., 08; Van Houtven & Norton, 08).
  - Bonsang (09), 11 Eu. countries: ditto and, substitution effect vanishes with heavy disability
• Daatland & Lowenstein (05); 5 Eu. countries, provision of social care services did not crowd-out family care; OA received more care

• Jonsson (03), Eu., citizen support for state provision of care; strongest in those countries where little exists, more taken-for-granted where it does exist.

• Can. res. (Chappell & Blandford, 91; Dosman, et al, 05); families call on formal system when no informal available or too many demands
Home Care/ Home Support

• 1970s and 80s period of expansion
• Mid-80s – early 90s, a Federal/Provincial/Territorial Sub-Committee on Continuing Care
• Early 90s, 7 provinces, person responsible for provincial continuing care system.
• Continuing Care was (and would be today) 3rd largest component of public health expenditures after hospitals and primary care
• Home care: 2% - 4% of public health care $$$
• All health care $$$: 88% are public
Dismantling Home Care

- Public $$$ to home care decreased:
  - 2000-2001 -3.4%
  - 2003-2004 -.7%
  - then levelled

- 18.6% increase in per capita *private* expenses
  (CIHI figures)
• Per capita spending increased more than number of users
• Health component increased as a share of services
• B.C. & Sask.: # of users decreased, service hours increased
  (CIHI; LeGoff; Penning et al.)
• Shorter hospital stays, increased demand for short term home care services (Deber)
• Hollowing out of medicare and provincial systems (Williams et al.)
• No longer a separate system but grouped under ‘other’ services; removing visibility
### Previous System

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Primary Care</th>
<th>Continuing Care</th>
<th>Drugs</th>
<th>Population and Public Health</th>
<th>Other Services (mental health, Ambulance, etc.)</th>
</tr>
</thead>
</table>

### Current System (National Policy Focus)

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Primary Care</th>
<th>Drugs</th>
<th>Population and Public Health</th>
<th>Other Services (long term residential care, home care, palliative care, respite care, etc.)</th>
</tr>
</thead>
</table>
3 Functions of Home Care

• Preventive
• Substitute for long-term care
• Substitute for hospital care
• A bit of history (Channelling projects in the U.S.; Weissart et al; lack of Can. research)
Recent Research

• Each has been shown that it can be cost-effective
• Prevention & delay (eg. Hollander)
• Substitution for long-term care
Home Care/Home Support can be Cost-Effective

• At same level of need, costs are 40% - 70% of care in a nursing home.
• Main component – home support worker
• Only time it’s more expensive – dying.
• Due to hospital costs NOT the social components.

(Hollander; Chappell; Pedlar & Walker)
Comparative Cost Analysis in 2000/2001 Dollars Including Out-of-Pocket Expenses and Caregiver Time Valued at Replacement Wages

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Victoria Community ($)</th>
<th>Victoria Facility ($)</th>
<th>Winnipeg Community ($)</th>
<th>Winnipeg Facility ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A: Somewhat Independent</td>
<td>19,759</td>
<td>39,255</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Level B: Slightly Independent</td>
<td>30,975</td>
<td>45,964</td>
<td>27,313</td>
<td>47,618</td>
</tr>
<tr>
<td>Level C: Slightly Dependent</td>
<td>31,848</td>
<td>53,848</td>
<td>29,084</td>
<td>49,207</td>
</tr>
<tr>
<td>Level D: Somewhat Dependent</td>
<td>58,619</td>
<td>66,310</td>
<td>32,275</td>
<td>45,637</td>
</tr>
<tr>
<td>Level E: Largely Dependent</td>
<td>NA</td>
<td>NA</td>
<td>35,114</td>
<td>50,560</td>
</tr>
</tbody>
</table>

• Substitution for hospital care
• Many of these studies focus on special patient populations (e.g., wound care, hip fracture, stroke)
• Italian (Landi et al) and Hong Kong (Leung et al) studies have revealed reduced hospitalizations
• Recent changes (e.g., shortened length of stay in hospital)
Past Evidence of Cost Avoidance

• The BC Planning and Resource Allocation Model developed in 1989 shifted clientele from residential care to home care, while the overall utilization rate remained relatively constant.

• The substitution of home care for residential care resulted in an annual cost avoidance of some $150 million per year by the mid-1990s.
How can Home Care be Cost-effective and Not a Cost Add-on?

• Home care valuable in its own right
• AND it can enhance value for money
• Requires single point of entry
• Requires standard assessments
• Requires system level case managers who stay with client irrespective of location of care
• Requires an integrated system of care.
• Can be expanded to include non-health sector
An Integrated Care System

A capitated system where funds are provided for home & community care and residential and/or hospital care (PACE in U.S.)

OR

A single administration and budget for the whole system of care (B.C., 1990s)
## Synthesis of Integrated Models of Care for the Elderly With Positive Evaluations

<table>
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<tr>
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<tbody>
<tr>
<td>System of Integrated Care for Older Persons (SIPA)</td>
<td>SIPA</td>
<td>SIPA</td>
</tr>
<tr>
<td>Program for All Inclusive Care for the Elderly (PACE)</td>
<td>PACE</td>
<td>PACE</td>
</tr>
<tr>
<td>Rovereto Model (noted under case management)</td>
<td>Rovereto Model</td>
<td>Rovereto Model</td>
</tr>
<tr>
<td>Hospital Admission Risk Program (HARP)</td>
<td>HARP</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>PRISMA mentioned but evaluation not completed at the time of writing</td>
<td>Program of Research to Integrate Services for the Maintenance of Autonomy Model (PRISMA)</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Hong Kong Model</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Arizona Model (early 1990s)</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>B.C. Continuing Care Model (early 1990s)</td>
</tr>
</tbody>
</table>
The ECCF Framework for Organizing Integrated Systems of Care

### Philosophical and Policy Prerequisites

1. Belief in the Benefits of Systems of Care
2. A Commitment to a Full Range of Services and Sustainable Funding
3. A Commitment to the Psycho-Social Model of Care
4. A Commitment to Client-Centered Care
5. A Commitment to Evidence-Based Decision Making

### Best Practices for Organizing a System of Continuing/Community Care

**Administrative Best Practices**
1. A Clear Statement of Philosophy, Enshrined in Policy
2. A Single or Highly Coordinated Administrative Structure
3. A Single Funding Envelope
4. Integrated Information Systems
5. Incentive Systems for Evidence-Based Management

**Service Delivery Best Practices**
6. A Single/Coordinated Entry System
7. Standardized, System Level Assessment and Care Authorization
8. A Single, System Level Client Classification System
9. Ongoing, System Level Case Management
10. Communication with Clients and Families

### Linkage Mechanisms Across the Four Population Groups

1. Administrative Integration
2. Boundary Spanning Linkage Mechanisms
3. Co-Location of Staff

### Linkages With Hospitals

1. Purchase of Services for Specialty Care
2. Hospital “In-Reach”
3. Physician Consultants in the Community
4. Greater Medical Integration of Care Services
5. Boundary Spanning Linkage Mechanisms
6. A Mandate for Coordination

### Linkages With Primary Care/Primary Health Care

1. Boundary Spanning Linkage Mechanism
2. Co-Location of Staff
3. Review of Physician Remuneration
4. Mixed Models of Continuing/Community Care and Primary Care/Primary Health Care

### Linkages With Other Social and Human Services

1. Purchase of Service for Specialty Services
2. Boundary Spanning Linkage Mechanisms
3. High Level Cross-Sectoral Committees

Application of the Framework to the Elderly

Acute Care
- Hospital Services
  - Day Hospitals
  - Hospital-Based Geriatric Units

Short Stay Assessment and Treatment Centres

Residential Services
- Group Homes
- Assisted Living
- Supportive Housing
- Residential Respite Care
- Residential Palliative Care

Chronic/Extended Care Facilities
- Long-Term Care Facilities/Nursing Homes

Tertiary/Quaternary Care Level

Secondary Care Level

Primary Care Level

Home-and Community-Based Services
- Meal Programs
- Home Nursing Care
- Home Support Services (HOMEMAKERS/CARE AIDES)
- Adult Daycare/Support System-Level Case Management
- Community-Based Respite Care
- Community-Based Palliative Care

Adult Foster Care
- Physician Care Facilitators
- Self-Managed Care Options
- Home Based Rehabilitation Care
- Specialty Transportation Services
- Life/Social Skills Training and Support
- Technical Aids, Equipment and Supplies
- Community Emergency Services/Crisis Support

Vertical and Horizontal Integration Through Case Management
Recent recognition

• Increasing calls for expanded home care/community care

• Health Council of Canada’s report *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?*

• Question remains: who pays?

• If home/community care is largely private, as the current trend suggests, is integrated care possible?
The Conundrum

• Ongoing care needs due to functional deficits are health problems requiring ‘medically necessary’ care.

• Maximizing independence and minimizing rate of deterioration often requires non-professional home care services.

• Home care is a low cost alternative to hospital & residential care for both the preventive and substitution functions of home care.
Conclusions

• It is possible to have both an appropriate and cost-effective health care system for an ageing society.

• It requires an expanded home/community care system that supports both OA and their caregivers and within an integrated system of care.

• It requires political will and grassroots action