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

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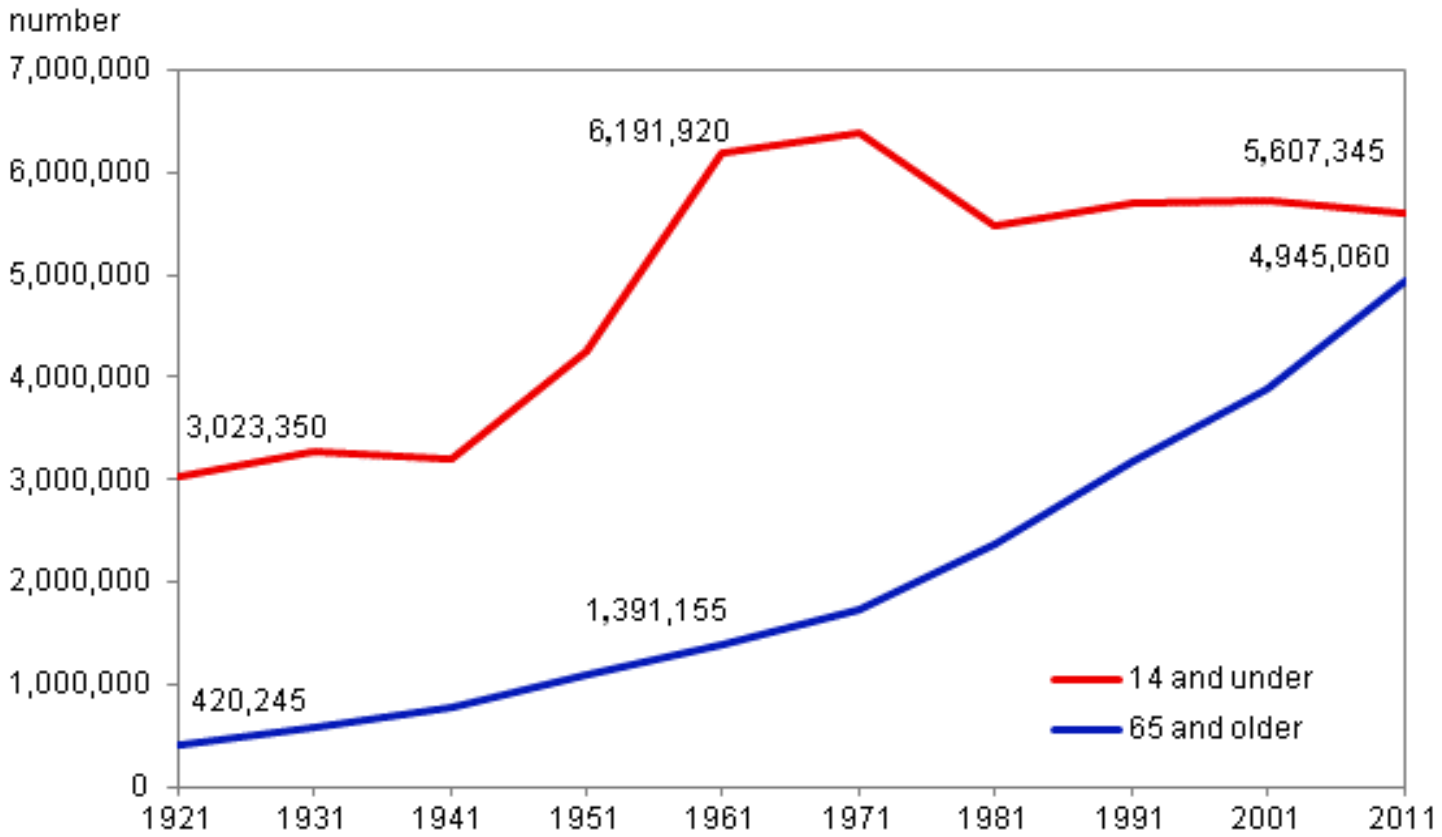
The Starting Point

- 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 requires 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.

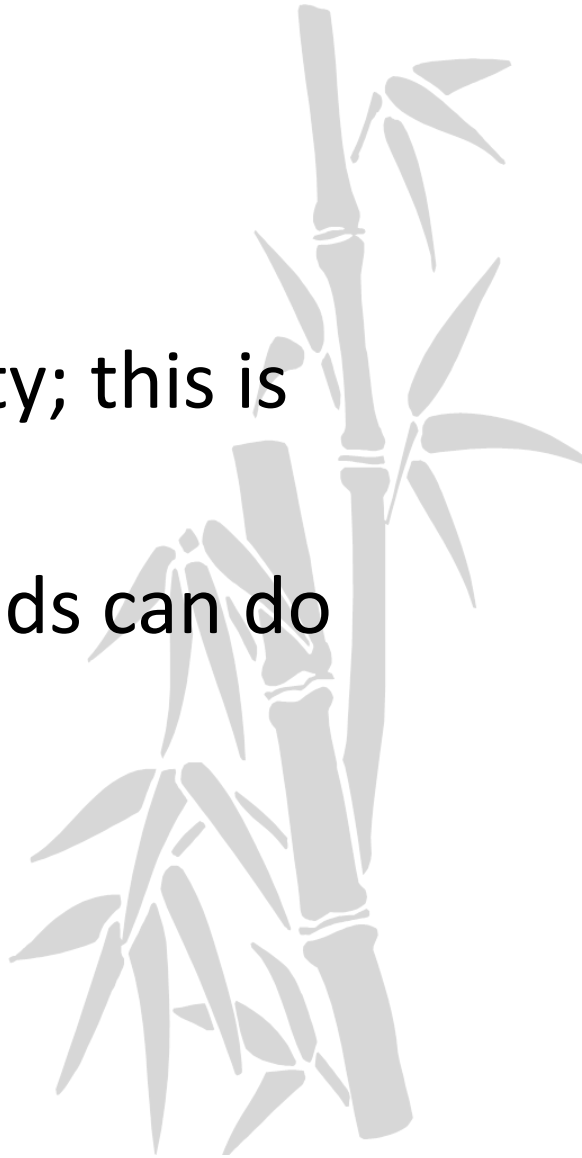
When Baby Boomers are Elderly?

- 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

Hospitals	Primary Care	Continuing 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.)

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

Level of Care	Victoria		Winnipeg	
	Community ($)	Facility ($)	Community ($)	Facility ($)
Level A: Somewhat Independent	19,759	39,255	N/A	N/A
Level B: Slightly Independent	30,975	45,964	27,313	47,618
Level C: Slightly Dependent	31,843	53,843	29,094	49,207
Level D: Somewhat Dependent	58,619	66,310	32,275	45,637
Level E: Largely Dependent	N/A	N/A	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.

- Substitution for hospital care
- Many of these studies focus on special patient populations (eg, wound care, hip fracture, stroke)
- Italian (Landi et al) and Hong Kong (Leung et al) studies have revealed reduced hospitalizations
- Recent changes (eg., 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

Low, and Brodaty (2011)	**MacAdam (2008)**	**Béland and Hollander (2011)**
System of Integrated Care for Older Persons (SIPA)	SIPA	SIPA
Program for All Inclusive Care for the Elderly (PACE)	PACE	PACE
Rovereto Model (noted under case management)	Rovereto Model	Rovereto Model
Hospital Admission Risk Program (HARP)	HARP	N/A
N/A	PRISMA mentioned but evaluation not completed at the time of writing	Program of Research to Integrate Services for the Maintenance of Autonomy Model (PRISMA)
N/A	N/A	Hong Kong Model
N/A	N/A	Arizona Model (early 1990s)
N/A	N/A	B.C. Continuing Care Model (early 1990s)

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

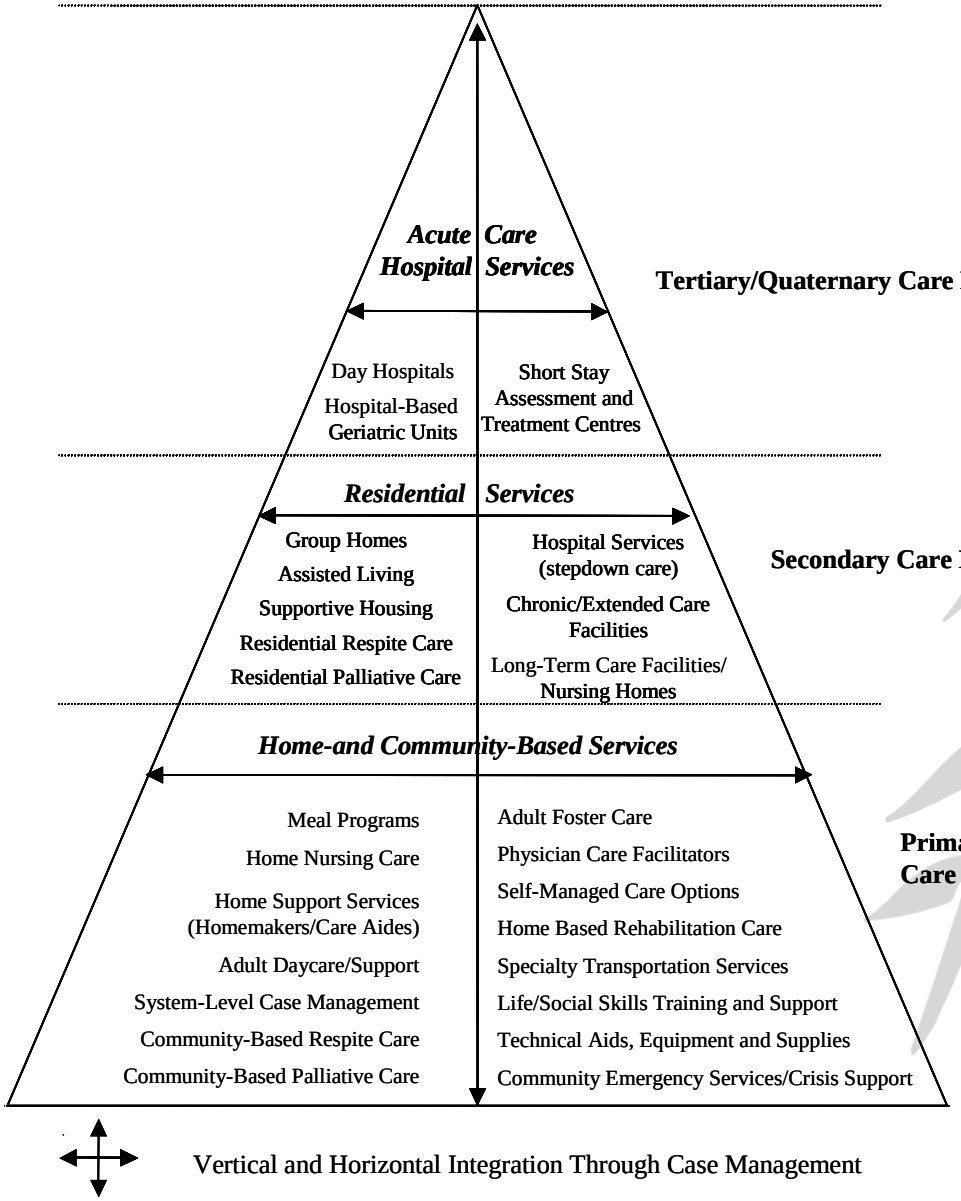
1. Boundary Spanning Linkage Mechanism
2. Co-Location of Staff
3. Review of Physician Remuneration
4. Mixed Models of Continuing/Community Care and Primary Care / Primary Health Care

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

Source: Hollander, M.J., and M. Prince. 2007. Organizing Healthcare Delivery Systems for Persons with Ongoing Care Needs and Their Families: A Best Practices Framework. *Healthcare Quarterly 11* (1), 42-52.

Application of the Framework to the Elderly



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