

Overview of Continuing Care and How it Can Contribute to the Sustainability of the Canadian Health Care System

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Time for a Change

- Our work showing the cost-effectiveness of home care and models of integrated care is well documented. However our arguments that integrated systems of care can achieve significant cost avoidance, and contribute to the sustainability of our health care system, have not been taken up by policy makers and analysts.
- This is why we recently published our book entitled Aging in Canada. We believe that there are positive solutions to enhancing the sustainability of our health care system and wish to have these positive messages enter into the public policy debate.

Ref: Chappell, N. and Hollander, M.J. (2013). Aging in Canada. Don Mills, ON: Oxford University Press.

Terminology

- We shall be speaking today about coordinated/integrated models of care for the elderly and persons with disabilities. In order to cover the broader concept of such care models, we shall use the term “continuing care”. This is a term which has often been used in Western and Atlantic Canada.
- Continuing Care was (in the late 1980s and the early to mid 1990s), 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.

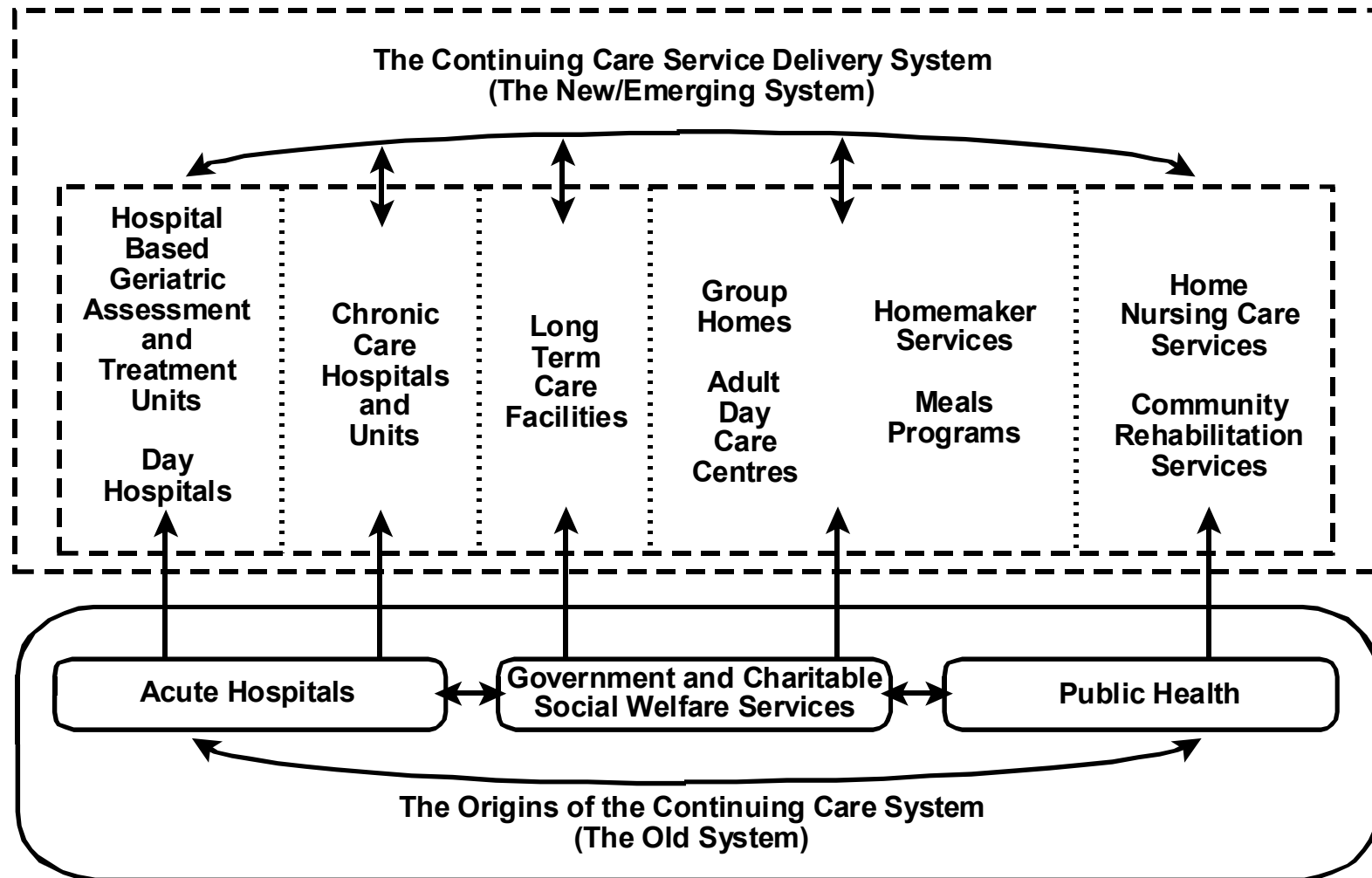
So What is Continuing Care?

- Classically, continuing care is a vertically and horizontally integrated system of service delivery with a broad community base for people with functional disabilities and chronic illnesses.
- It includes assessment and case management, home care (including short term hospital replacement home care), home support, palliative and respite care, long term residential care, geriatric units in hospitals, and other related services. New services are being added over time.
- The term refers to care continuing over time, and across types of services (e.g., hospital to home care).

So What is Continuing Care? (Cont'd)

- What is very important, and what is generally recognized by people working in the field, is that it is the integration of medical, health, supportive, community and residential/institutional care into one system that is the essence of the continuing care model and is why it is such a good fit to the actual needs of people with ongoing care needs such as the elderly and people with disabilities. We need to broaden this understanding to decision makers, particularly at the national level.

The Emergence of the Continuing Care System



A Short History of Continuing Care in Canada

- Continuing care started in the mid 1970s in Manitoba and an integrated system of care was developed in BC between 1978 and 1983.
- By the mid-1980s the BC and Saskatchewan Ministries of Health had Executive Directors of Continuing Care.
- In the early 1990s some 7 provinces had, at various points in time, one person responsible for their 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.
- Continuing care has been in decline since the mid-1990s

Previous Canadian System (early/mid 1990s)

Hospitals	Primary Care	Continuing Care	Drugs	Population and Public Health	Other Services (mental health, Ambulance, etc.)
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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.)
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- Continuing Care was (in the late 1980s and the early to mid 1990s), 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.

Benefits of Integration

- We are stressing coordinated/integrated care delivery systems for persons with ongoing care needs because they have the following benefits:
 - They are good clinically because they allow for well coordinated seamless care for clients across a wide range of services from Meals on Wheels to specialized geriatric assessment and treatment centres in hospitals.
 - They are good from a policy perspective because policies can be made at the broader systems level, across all care services in the system, to the benefit of the client.

Benefits of Integration (cont'd)

- They are good economically because such systems allow for trade offs between, for example, less costly home care and more expensive long term facility care or acute care. Such efficiencies can increase value-for-money within the home and community care system, and within the broader health care system.
- They are good because it is possible simultaneously to both reduce costs (or increase efficiencies) and provide better care to clients.

Main Points

- Comments about the dangers of the “grey tsunami”, and the unsustainability of our health care system, have been greatly exaggerated and, in fact, are examples of ageism (“the growth in the elderly population will bankrupt our health care system”).
- The impact of our growing elderly population adds less than one percent to overall health care costs per year – even conservative economists agree on this. Other factors account for most of the increases in health care costs.
- There is clearly no crisis nationally. The percentage of GDP spent on health care increased from 10% to 10.5% over a fifteen year period from 1992 to 2007, before the world wide financial crisis. At its worst it rose to 11.9% but as our economy recovers this percentage has been coming down.

Main Points (Cont'd)

- Care delivery for seniors has been in a downward policy drift for over 20 years. The improvements proposed in the early 1990s were not implemented so we now face a similar situation in terms of eldercare as we did more than 20 years ago.
- This constitutes a movement to less, and less coordinated, services achieved by stealth. Major policy changes such as disenfranchising seniors with low level care needs were simply implemented with little or no discussion and were not made clear to the public as election issues.

Main Points (Cont'd)

- This downgrading of services occurred under all political parties and, thus, does not seem to be a party issue. In fact some cross party committees have recently been formed at the federal and provincial levels to try to improve seniors care. These efforts are to be supported and applauded.
- There has been a clear shift away from recognizing that seniors care is a mix of health and social services, resulting in a medicalization of care and, as a consequence, a policy inspired cost escalation spiral.

Main Points (Cont'd)

- The cost escalation spiral works as follows. Hospitals ask for more money. Officials reduce budgets for home support services (as they are “non-professional and not really health services”) to generate money for hospitals. The elderly are cut from service and can not cope on their own without assistance resulting in greater numbers of admissions to hospitals and long term care facilities.
- Hospitals complain about increased workloads due to these new demands by elderly persons and ask for more money and the cycle repeats.
- The consequence of this cycle is that we are, as a matter of public policy, substituting high cost hospital services for low cost home support services and, thus, increasing overall health care costs.

Main Points (Cont'd)

- We are proposing an approach that enhances care delivery while at the same time generating significant cost avoidance to enhance the sustainability of our health care system.
- There are two parts to our argument. More funding improves home care. However it is only through substituting lower cost home care for higher cost hospital and facility care that one can achieve cost avoidance. This substitution can only take place in an integrated system of care.
- Putting more money into home care, or chronic care models which combine primary care and home care, in a splintered system will not reduce requests for additional funding from the hospital and long term care facility sectors. Thus, new funding will constitute an add on cost. However, combined primary care/home care could be a component part of a larger, integrated model of continuing care.

Cost-Effectiveness of the Preventive Function of Home Care and the Role of Home Support

- In the fall of 1994, a policy was put into place in British Columbia to cut Personal Care clients (those with the lowest care needs) who only received house cleaning services.
- Most cuts were made in the first half of 1995.
- They were different patterns of response by Health Units (HUs) to the policy.
- Some HUs did not cut services, some cut moderately and some cut severely.

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	5,052	6,683	9,654	11,903
	No Cuts	4,535	5,963	6,771	7,808

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

- 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.

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

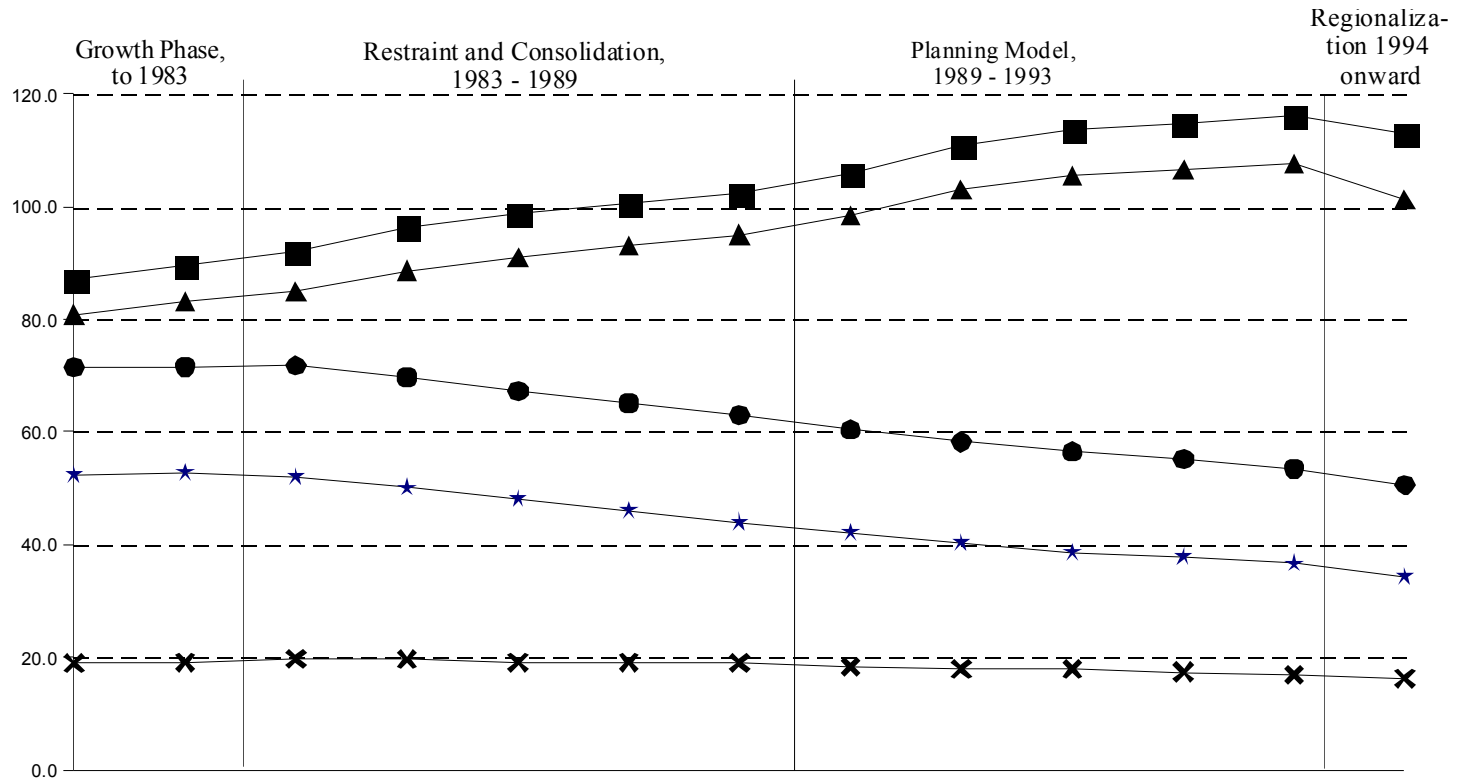
Level of Care	Victoria		Winnipeg	
	Community (\$)	Facility (\$)	Community (\$)	Facility (\$)
Level A: Somewhat Independent	19,759	39,255	N/A	N/A
Level B: Slightly Independent	30,975	45,964	27,313	47,618
Level C: Slightly Dependent	31,848	53,848	29,094	49,207
Level D: Somewhat Dependent	58,619	66,310	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.

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 resulting in annual cost avoidance of an estimated \$150M by 1995.
- It is believed similar opportunities for cost-effective substitutions still exist.

Major Phases In The Utilization Of Home Care & Residential Care



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
■ 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
▲ 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
● 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.

International Findings

- Stuart and Weinrich in a 2001 study comparing Denmark (which has an integrated model of care and a strong reliance on home and community services) and the United States, found that from 1985 to 1997 per capita expenditures on continuing care for seniors increased by 8% in Denmark and 67% in the United States. Many of the efficiencies were achieved by increasing home care and reducing facility beds.

Source: Stuart, M., & Weinrich, M. (2001). Home- and community-based long-term care: Lessons from Denmark. *The Gerontologist*, 41 (4), 474-480.

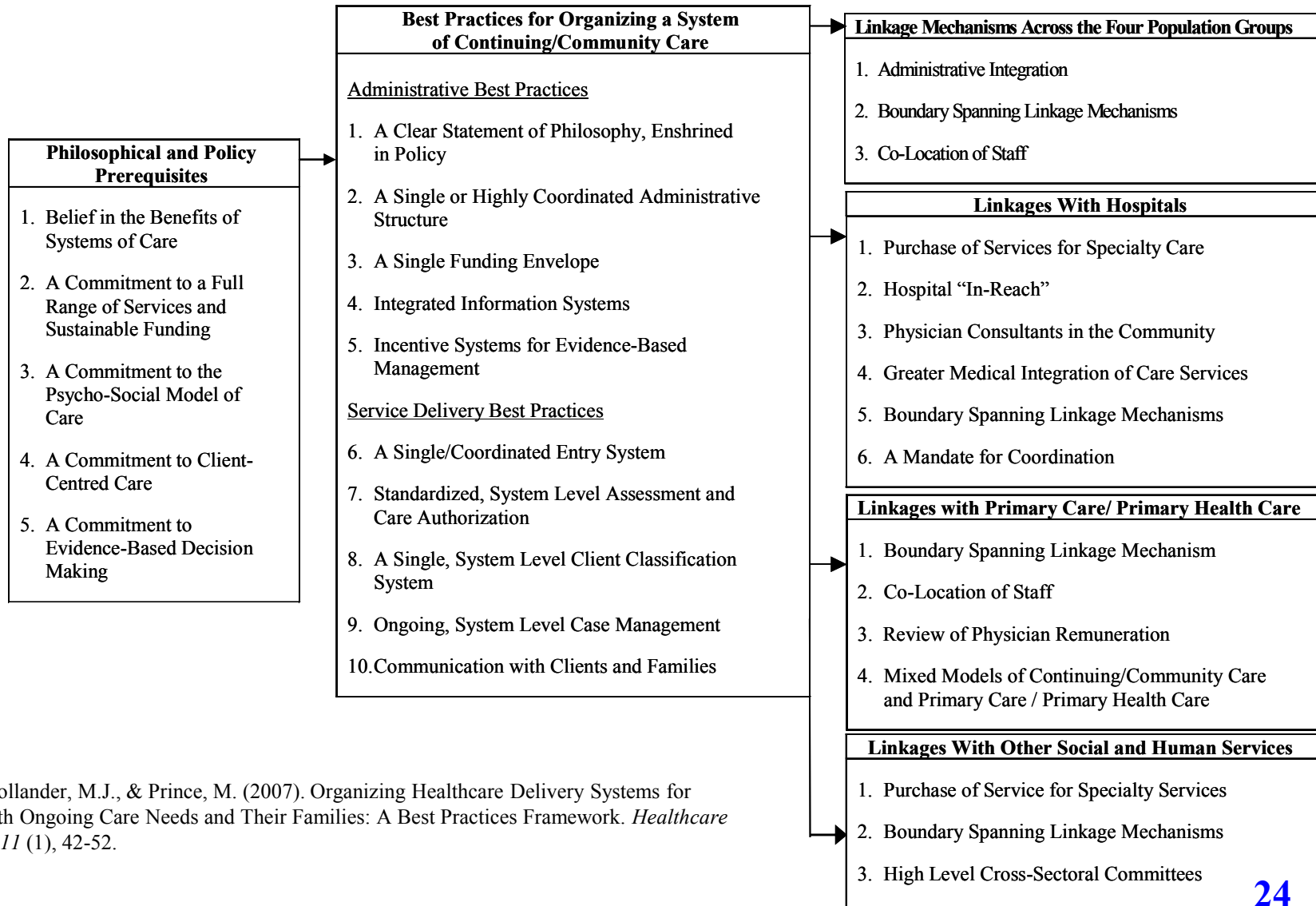
- Veterans Affairs Canada has also substituted home care for residential care.

Source: Pedlar, D., & Walker, J. (2004). The Overseas Service Veteran (OSV) At Home Pilot: How choice of care may impact use of nursing home beds and waiting lists (Brief Report). *Canadian Journal on Aging*, 23(4), 367-369.

Framework for Organizing Care Delivery for Persons with Ongoing Care Requirements (the Enhanced Continuing Care Framework)

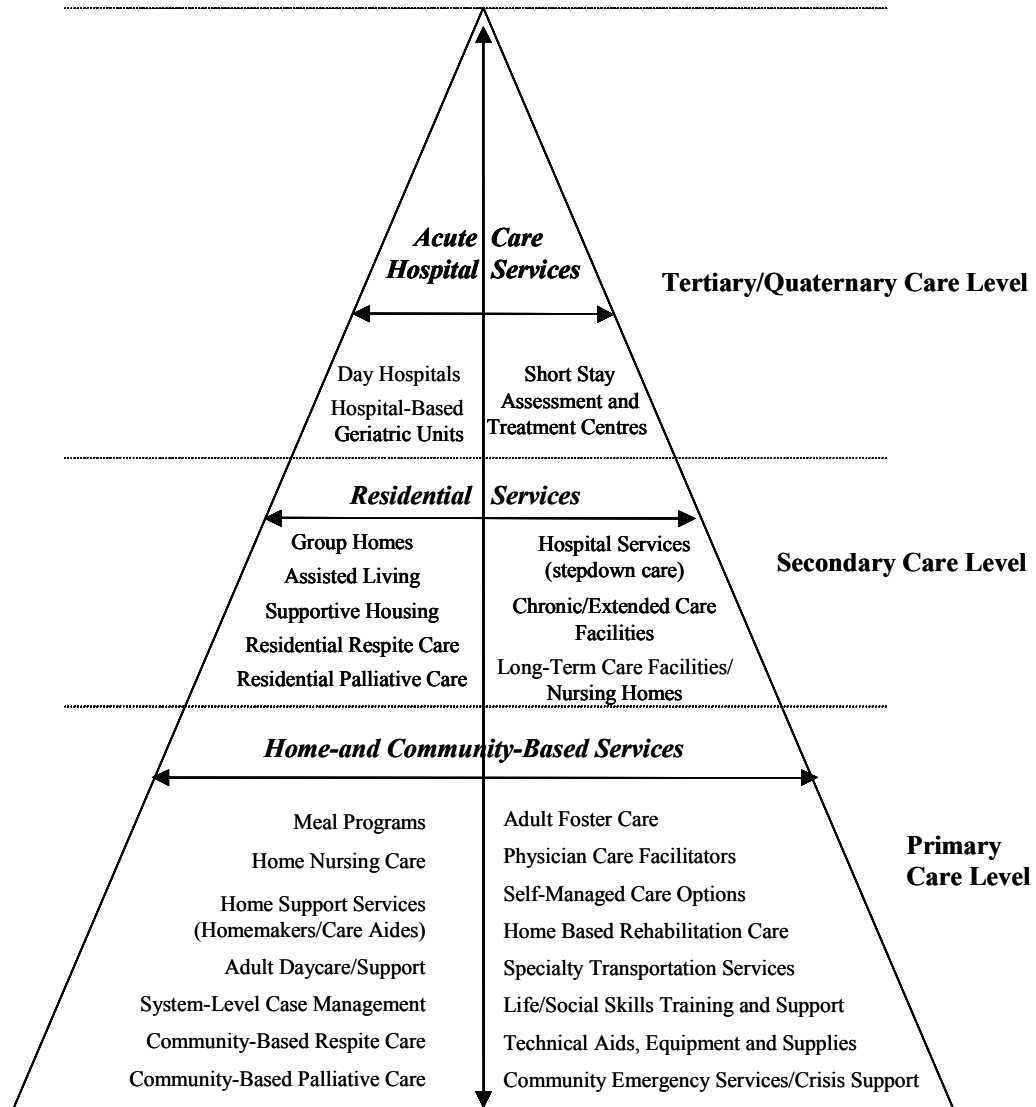
- Conducted national studies on service delivery systems for:
 - The Elderly
 - Persons with Disabilities
 - Persons Requiring Mental Health Services
 - Children with Special Needs
- Also conducted survey of leading Canadian experts on the topic of integrated care systems.
- This framework was rated as the best for organizing systems of care delivery for the elderly in an independent, international review of models/frameworks.

The Enhanced Continuing Care Framework for Organizing Integrated Systems of Care for People with Ongoing Care Needs (the Hollander and Prince Framework)



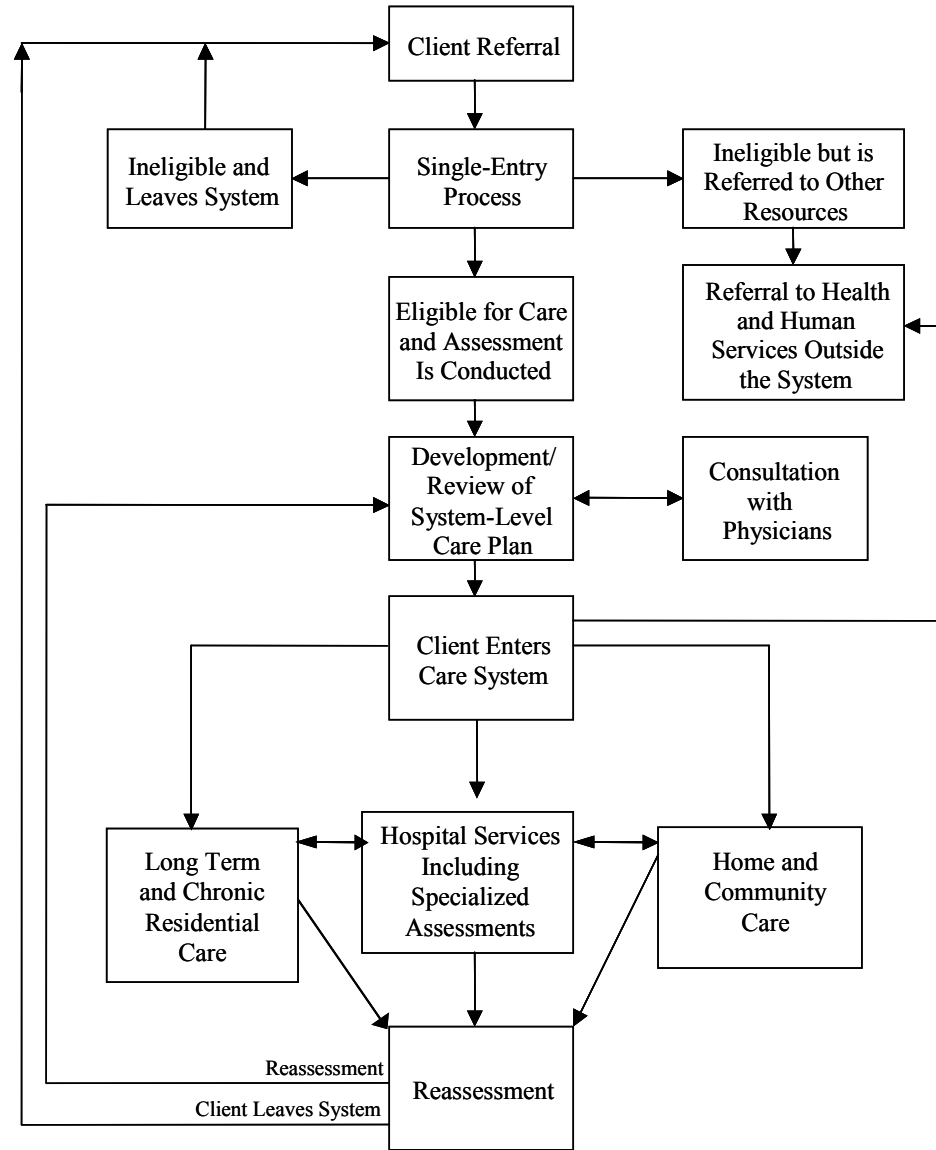
Source: Hollander, M.J., & Prince, M. (2007). Organizing Healthcare Delivery Systems for Persons with Ongoing Care Needs and Their Families: A Best Practices Framework. *Healthcare Quarterly*, 11 (1), 42-52.

Application of the Framework to the Elderly



↕ Vertical and Horizontal Integration Through System Level Case Management

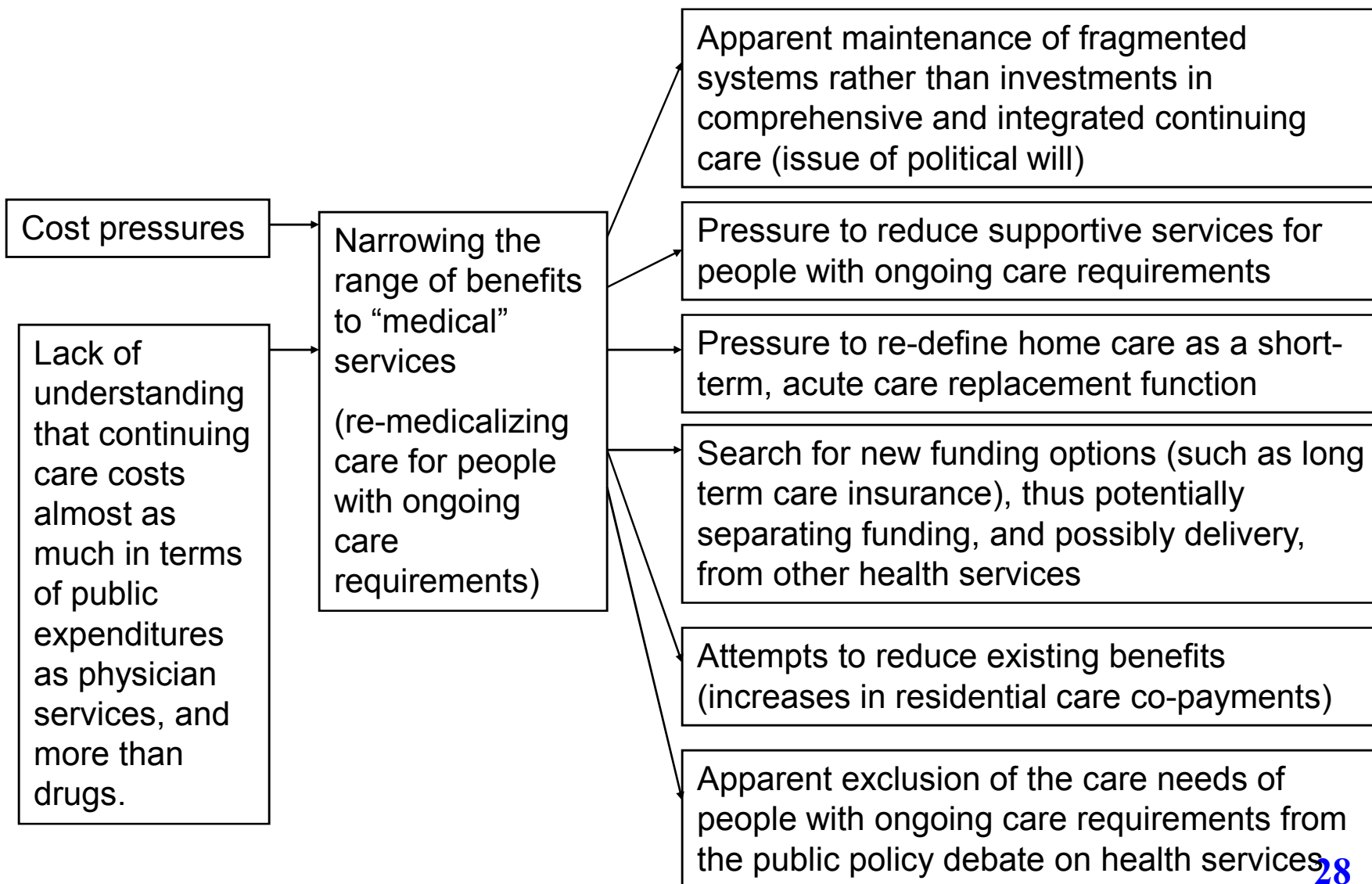
A Schematic of How A Client Goes Through the System of Care



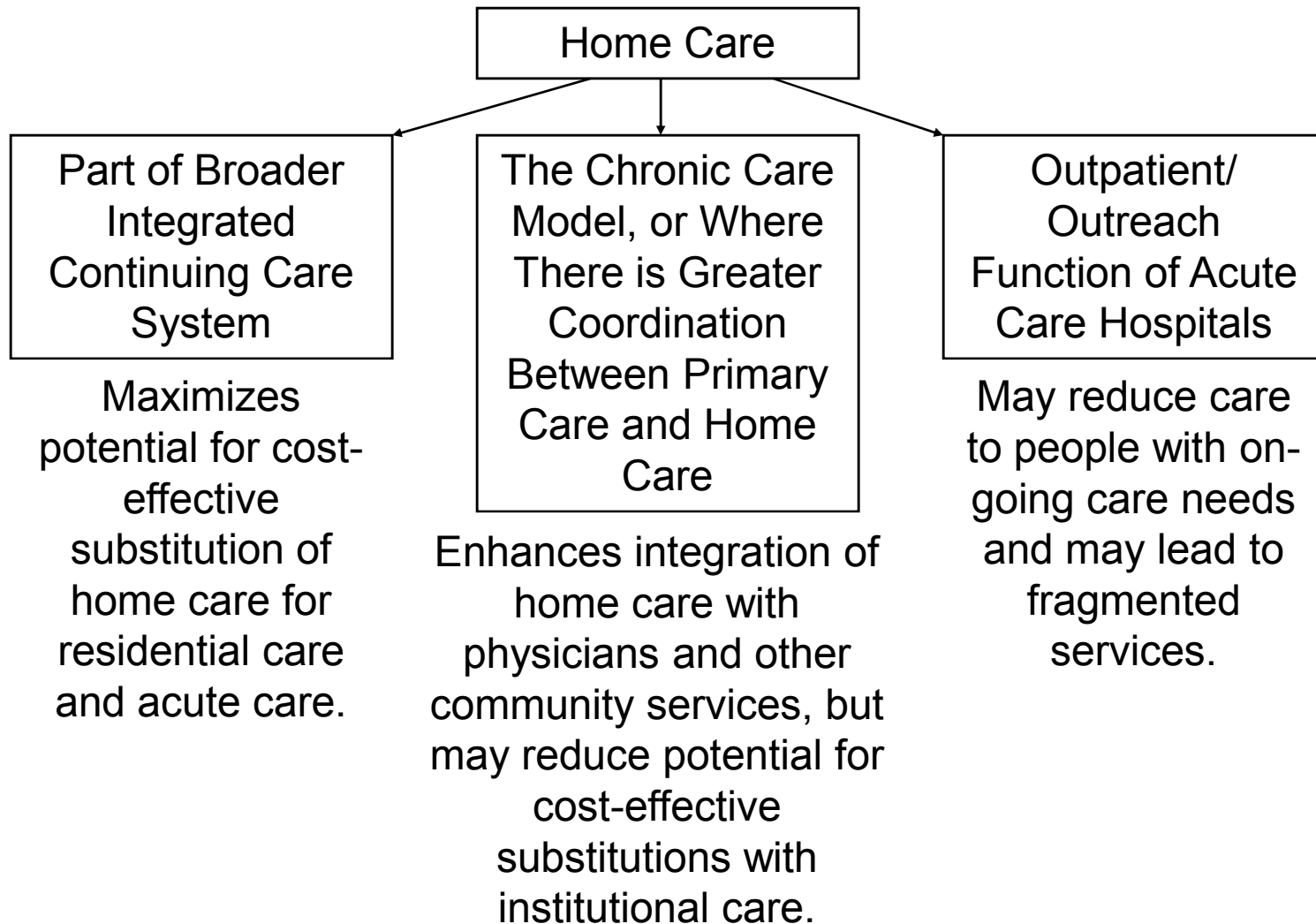
Policy Choices

- We do recognize that many jurisdictions have developed laudable new programs, but it is now time to come together to develop a system-wide solution. Worthy care initiatives can be rolled into this broader, system-wide approach, as appropriate.
- The first step to achieving actual progress will be for governments to again recognize integrated care delivery for persons with ongoing care needs as a major component of our health care system alongside acute care, physician care and population and public health. This recognition existed in the early 1990s but has been lost and now the component parts of an integrated system have been splintered and are seen as separate “Other” health services. This pattern needs to be reversed.

Current Canadian Trends in Policy for Persons With Ongoing Health Needs



Options for the Future of Home Care



Key Messages For Decision Makers

- We need to think in terms of integrated and coordinated systems of care. There is essentially no evidence that fragmented systems provide good care or are cost-effective. Thus, it is critical for senior decision makers to re-recognize Continuing Care as a major component of our health care system.
- Home support services are health-related services and are critical to keeping people out of more costly hospital care and long term residential care. Even a small amount of support can go a long way. Choosing to adopt a narrow definition of health care will be counterproductive and may well lead to increasing pressures on more costly, institutional services resulting in a negative cost spiral.

Key Messages (Cont'd)

- There are now well-developed frameworks for organizing health services for people with ongoing care needs which have the potential to simultaneously improve care and reduce costs. Not having a plan is no longer a viable reason for not dealing with complex problems related to systems of care delivery.
- There are real and far-reaching policy choices to be made. Not making a decision is as much a policy choice as making a decision. Choices will be made. It is hoped that the decisions will be wise and informed ones.

Key Messages (Cont'd)

- There is a need to not only support older adults, but also, their caregivers.
- Policy is made by people and can be changed by people. Whether we improve services or regress backwards is in the hands of our policy makers.