

# **Hollander Analytical Services Ltd.**

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## **Unfinished Business: The Case for Chronic Home Care Services, A Policy Paper**

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## *About Hollander Analytical Services Ltd.*

Hollander Analytical Services Ltd. is a national health services research and evaluation company. Headquartered in Victoria, BC, it is a virtual organization which has a small core staff and approximately 30 Scientific Advisors and Associates across Canada. Additional sub-contractors and consultants from across Canada are also used on projects as required. A particular strength of the company is its ability to assemble high level teams which are customized to each project in order to meet the unique requirements of the project funder. Hollander Analytical has been in operation for over seven years and has conducted a number of large scale health policy research and evaluation studies in the fields of Continuing Care (long term care and home care) and Primary Health Care.

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## **EXECUTIVE SUMMARY**

### **Introduction**

The Romanow Commission and the Kirby Committee left a major gap in their policy recommendations when they did not directly address the role of home care services for persons with ongoing care needs, that is, those with chronic health conditions. These reports, and the First Ministers' Health Accord, have focused on short term, and particularly acute care replacement, home care. This paper argues that the current approach to home care is misguided and may well lead to an increasing cost spiral in health care services and, in particular, hospital services and long term care residential services.\*

The focus on short term home care is designed to result in cost-effective savings in acute care by substituting less costly home care services for more expensive acute care services by facilitating reductions in the length of stay in hospital. Even assuming investments in short term home care prove to be successful, they still only deal with the output (discharge) side of the equation. They do not deal with the input side (admissions). While we may become more efficient at taking people out the hospital, these efficiencies may well be swamped by an ever-increasing number of persons making demands on hospitals and long term care facilities. This input side is where support for chronic home care services can have a significant impact.

### **Findings on the Cost-Effectiveness of Long Term, or Chronic, Home Care**

Hollander in a study of the cost-effectiveness of chronic home care found that over time, and for all levels of care needs, home care, on average, was significantly less costly than care in a long term care facility. For example, average annual costs to government for people with moderate care needs (Intermediate care 1 or IC1) in the mid-to-late 1990s, in British Columbia, was \$9,624 for persons on home care and \$25,742 for people in institutions. For people at the highest, or chronic, level of care (Extended Care) the corresponding costs were \$34,859 and \$44,233.

It should be noted that the savings from substituting home care services for residential services are not theoretical. Actual savings were achieved in British Columbia by holding down future construction of long term care facilities and making investments in home care.

### **The Role of Home Support**

What role has home support played in regard to the cost-effectiveness of long term, or chronic, home care? It turns out that home support is central to this form of home care and the cost-effective substitutions it can engender. Hollander provides evidence on the relative costs of home support and professional home care (e.g., nurses, physiotherapists) in chronic home care.

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\* In this report we use the term chronic home care and long term home care interchangeably. We are referring to home care for persons with ongoing, or chronic, care needs who, typically, are deemed to need home care and/or home support services for more than a 90 day period. The purposes of the home care services provided are to: maintain optimal functioning and prevent deterioration in functional status; serve as a substitute for long term care residential services; and assist people who would otherwise need to remain in, or enter, acute care hospitals.

He found that approximately 90% of the expenditure for chronic home care, for people with higher level care needs, were for home support services and 10% were for professional services.

There is also some interesting preliminary data which shows that home support may be able to substitute for acute care services. Hollander found that for the highest level of care (chronic or extended care) there seemed to be a possible substitution effect between home care and acute care services. There was a period of restraint on hospital utilization in British Columbia in the mid-1990s. This allowed for an analysis of the relative cost distribution of health care services between a period of moderate restraint (the 1993/94 cohort of clients) and more severe restraint (the 1997/97 cohort).

The results indicated that, for high care needs clients, there was a major resource shift from hospital services to home support services, while professional home care services remained relatively constant. Thus, in the early-to-mid 1990s the average annual cost of hospital care was \$13,416 for chronic care clients and the cost of home support services was \$10,381. In the mid-to-late nineties the comparable costs were \$9,458 for acute care and \$13,195 for home support, for a shift in relative costs of some \$3,000. Thus, more was spent on home support for the 1996/97 cohort and this amount represented a significant portion of the decrease in annual hospital costs between the two cohorts.

Further evidence of the cost-effectiveness of chronic home care, and particularly home support, is provided in a study of the cost-effectiveness of preventive home care. Hollander conducted a study of a natural experiment which occurred in British Columbia in the 1994 to 1995 period in which some health regions cut people from care who were at the lowest level of care need and were only receiving housecleaning services, and some regions did not make such cuts. He studied the overall costs to the health care system of people who were cut from service in two health regions to people who were not cut from service in two similar regions. In the year before the cuts the average annual cost per client for those who were cut from service was \$5,052 and the cost per client for the comparison group was \$4,535. For the third year after the cuts were made the comparative costs were \$11,903 and \$7,808, respectively, for a net difference of some \$3,500. Thus, on average, the people who were cut from care cost the health care system some \$3,500 more in the third year after the cuts than people who were not cut from service.

### **Home Care in a Broader Continuing Care Context**

Hollander and Chappell in the Synthesis report of the National Evaluation of the Cost-Effectiveness of Home Care present a number of policy recommendations regarding home care. They note that home care, in order to more readily make the types of substitutions required to achieve greater effectiveness, needs to be part of a broader, integrated system of home care and residential care, often referred to as continuing care. By having administrative and fiscal control over such a large, integrated system of care senior executives and policy makers can take steps to ensure that appropriate substitutions of home care for acute care and residential care can, in fact, take place.

It is generally not recognized by policy makers that a properly constructed continuing care system would, in terms of public expenditures, constitute the third largest component of the

Canadian health care system after hospitals and medical services. By extrapolating data from the early 1990s, and using the little current data which does exist, Hollander estimates current annual public expenditures on continuing care to be some \$11 to 13 billion, which is more than current public expenditure on drugs (while Canadians spent some \$18 billion on drugs in 2002, only 36% or \$6.5 billion was paid for by government).

In a study which takes the above theme further Hollander and Prince, in a synthesis of a large national study, clearly present the current problems of lack of integration and systems fragmentation for health care delivery systems for seniors, persons with disabilities, persons with chronic mental health conditions, and children with special needs. These are all people who have ongoing, or long term, care needs. The authors found that there was a significant overlap in the care services required by these populations and problems related to the lack of integration in their respective care delivery systems. They go on to lay out a clear, best practices blueprint for how to organize an efficient and effective health care service delivery system for persons with ongoing care requirements. This is not a theoretical document. Their model simply extends, and/or combines, best practices for service delivery systems which currently exist, or have existed, in Canada. Thus, the model has a clear empirical basis in regard to an analysis of current problems, and builds on the best Canadian traditions in regard to service delivery systems for persons with ongoing care needs.

A final point to note is that some policy makers may have the misapprehension that focusing on chronic or long term care may significantly increase costs. In this regard it should be noted that all Provinces and Territories already have well developed, government funded, systems of long term home care. Thus, the cost to “top up” existing systems could be fairly modest if one builds on the systems which already exist.

The danger in focusing exclusively on short term home care is that the definition of home care will shift in the minds of policy makers and the public to equating home care with short term home care. This could lead to further encroachment on home care services, and particularly home support services, for people with ongoing care needs. This, in turn, could lead to a negative cost spiral in which home support funding is reduced and hospital funding is increased, leading to greater demands on acute and residential care services because people can no longer cope at home. This increased demand will then be used to justify further increases to institutional budgets resulting in further decreases to home support, leading to further rounds of increased demands on hospitals and long term care facilities, repeating the cycle over and over and increasing the overall costs of the Canadian health care system.

We now have evidence that long term home care, within an integrated model of care, has the potential to be a significant contributor to the increased efficiency and effectiveness of the Canadian health care system. We also have a clear picture of the inefficiencies and fragmentation of existing care delivery systems, and we have a well regarded solution for how to more optimally organize care delivery systems so that they can better contribute to increasing the efficiency, effectiveness and quality of the Canadian health care system. What is needed to achieve this goal is the political will to shift the current policy on home care, and continuing care, and to take the appropriate actions to improve our health care system.

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# **UNFINISHED BUSINESS: THE CASE FOR CHRONIC HOME CARE SERVICES, A POLICY PAPER**

## **Introduction**

The Romanow Commission<sup>1</sup> and the Kirby Committee<sup>2</sup> left a major gap in their policy recommendations when they did not directly address the role of home care services for persons with ongoing care needs, that is, those with chronic health conditions. These reports, and the First Ministers' Health Accord,<sup>3</sup> have focused on short term, and particularly acute care replacement, home care. This paper argues that the current approach to home care is misguided and may well lead to an increasing cost spiral in health care services and, in particular, hospital services and long term care residential services.\*

## **Short Term Home Care**

The focus on short term home care is designed to result in cost-effective savings in acute care by substituting less costly home care services for more expensive acute care services by facilitating reductions in the length of stay in hospital. In theory this should work, and additional investments in home care are naturally welcome. However, a review of the international literature and an extensive set of evaluation studies conducted for Canada's National Evaluation of the Cost-Effectiveness of Home Care reveal that reality is more complex. Hollander and Chappell<sup>4</sup> in the Synthesis Report of the National Evaluation of the Cost-Effectiveness of Home Care note that results on the cost-effectiveness of short term home care are mixed. They hypothesize that this may be due to a lack of appropriate linkages among the various components of the health system. Such linkages would allow for planned substitutions of home care for acute care services. Thus, simply adding money, without a targeted approach to substitution, may not achieve desired results. While investments in short term home care are welcome, and needed, how these investments are actually made will make the difference between a successful policy and a failed policy.

Assuming investments in short term home care prove to be successful, they still only deal with the output (discharge) side of the equation. They do not deal with the input side (admissions). While we may become more efficient at taking people out the hospital, these efficiencies may well be swamped by an ever-increasing number of persons making demands on hospitals and long term care facilities. This input side is where support for chronic home care services can have a significant impact.

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\* In this report we use the term chronic home care and long term home care interchangeably. We are referring to home care for persons with ongoing, or chronic, care needs who, typically, are deemed to need home care and/or home support services for more than a 90 day period. The purposes of the home care services provided are to: maintain optimal functioning and prevent deterioration in functional status; serve as a substitute for long term care residential services; and assist people who would otherwise need to remain in, or enter, acute care hospitals.

## The Pressure to Reduce Services

Provincial governments have noted that they have been under fiscal constraints. One of the responses to these pressures has been to narrow the concept and scope of what are considered to constitute “health” services. Thus, for example, there has been an ongoing set of policy steps to reduce eligibility for services for people receiving supportive home care services. These services such as cleaning, meal preparation and assisting with shopping, which are critical in helping people to maintain their independence, are being shifted onto family members, voluntary organizations and others because they are no longer deemed to be “health” services. This is the crux of the problem. People with ongoing and chronic care needs have verifiable medical conditions, that is, in the words of the Canada Health Act, they have “medically necessary” care needs. The conundrum is that the appropriate response to these medical conditions is, in large part, supportive care services, not medical services. For example, one does not need to be a nurse to assist someone to eat because he or she is weak and frail or does not have the dexterity to scoop up food and move it to his or her mouth, or the ability to cook a nourishing meal in the first place. However, a lack of support in eating will fairly quickly result in a visit to the hospital for malnutrition and dehydration. There is now a growing body of Canadian evidence that home care for persons with ongoing care needs can be a cost-effective intervention and can reduce demands on the institutional sector, thus increasing the overall efficiency of our health care system. In addition, there is also growing evidence that home support services are a central component of chronic home care services.

## Findings on the Cost-Effectiveness of Long Term, or Chronic, Home Care

Hollander<sup>5</sup> in a study of the cost-effectiveness of chronic home care found that over time, and for all levels of care needs, home care, on average, was significantly less costly than care in a long term care facility. For example, average annual costs to government for people with moderate care needs (Intermediate care 1 or IC1) in the mid-to-late 1990s, in British Columbia, was \$9,624 for persons on home care and \$25,742 for people in institutions. For people at the highest, or chronic, level of care (Extended Care) the corresponding costs were \$34,859 and \$44,233 (see Table 1).

**Table 1: Comparative Cost Analysis of Community and Residential Services - 1996/97 Cohort in 1996/97 Dollars**

Level of Care	Average Cost	
	Community (\$)	Facility (\$)
IC1	9,624	25,742
IC2	16,315	31,907
IC3	24,560	40,324
Extended Care	34,859	44,233

Source: Adapted from Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services*. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care.

Hollander et al<sup>6</sup> note that similar cost differences are seen if one adopts a broader societal perspective and includes out-of-pocket expenses and the care time of informal caregivers into the analysis (see Table 2).

**Table 2: 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

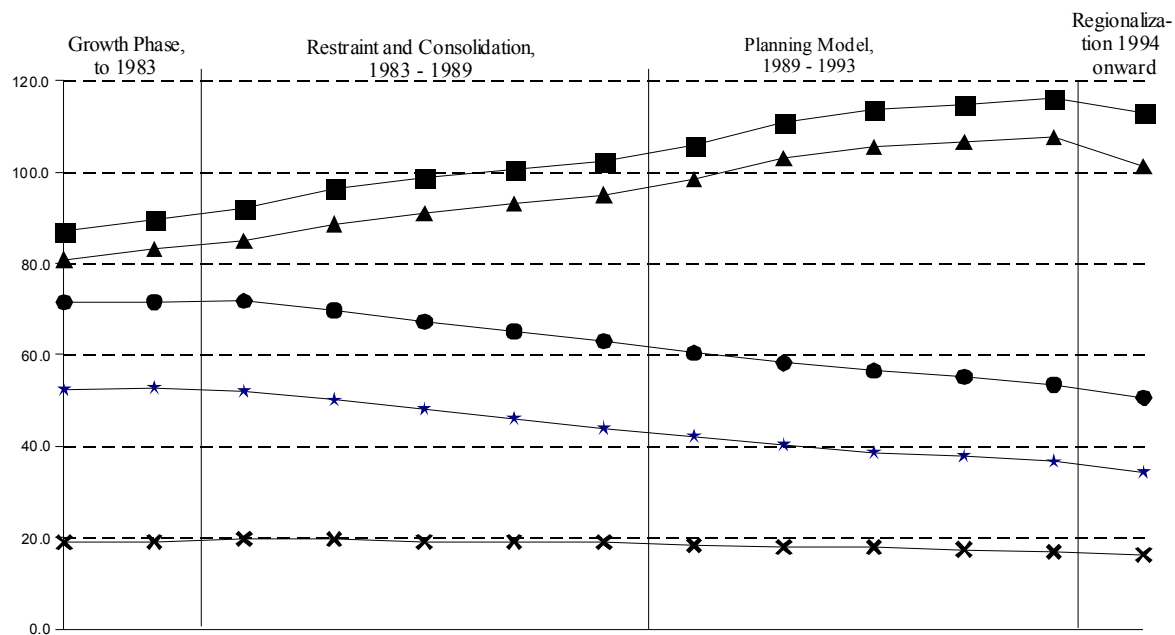
Source: Adapted from Hollander, M.J., Chappell, N.L., Havens, B., McWilliam, C., & Miller, J.A. (2002). Substudy 5: Study of the Costs and Outcomes of Home Care and Residential Long Term Care Services. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care.

It should be noted that the savings from substituting home care services for residential serves are not theoretical. Actual savings were achieved in British Columbia by holding down future construction of long term care facilities and making investments in home care.<sup>7</sup> Utilization of home and community care services in fiscal 1984/85 was 92 person years per 1,000 population 65 years of age and older and was 71.7 person years, or beds, for residential care for a total of 163.7. The overall utilization rate was also 163.7 for the 1994/95 fiscal year, but the utilization rate for residential services (long term care and chronic, or extended care, services) was reduced to 50.7 and the utilization rate of home care increased to 113. Thus, over a 10 year period, due to a pro-active policy of substituting home care services for residential services, the utilization of some 21 person years per 1000 population 65 years or older was shifted from residential care to home care for persons with ongoing care needs. Using the annual cost figures above, it is clear that a major saving was achieved by shifting people from residential care to home care. This can be seen in Figure 1 with the decreasing utilization rate of residential services over time, compared to the increasing utilization rate for community services.

### **The Role of Home Support**

What role has home support played in regard to the cost-effectiveness of long term, or chronic, home care? It turns out that home support is central to this form of home care and the cost-effective substitutions it can engender. Hollander<sup>8</sup> provides evidence on the relative costs of home support and professional home care (e.g., nurses, physiotherapists) in chronic home care. He found that approximately 90% of the expenditure for chronic home care, for people with higher level care needs, were for home support services and 10% were for professional services (see Tables 3 and 4).

**Figure 1: Major Phases In The Utilization Of Home Care and Residential Care Services**



	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
i 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
W 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.

Source: Adapted from Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services*. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care.

**Table 3: The Role of Home Support in Home Care for Home Based Clients (IC3 Clients) in 1991/92 Dollars**

Type of Service	1993/94 Cohort		1996/97 Cohort	
	\$	%	\$	%
Physician Services	1,313.64	6.2	1,263.88	6.8
Hospital Services	10,305.97	48.9	6,424.77	34.4
Professional Home Care	766.67	3.6	644.10	3.5
Home Support	7,016.47	33.3	8,338.51	44.7
Other	1,689.03	8.0	1,994.57	10.7
Total	21,091.78	100	18,665.83	100

Source: Adapted from Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services*. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care.

There is also some interesting preliminary data which shows that home support may be able to substitute for acute care services. Hollander<sup>9</sup> found that for the highest level of care (chronic or extended care) there seemed to be a possible substitution effect between home care and acute care services. There was a period of restraint on hospital utilization in British Columbia in the mid-1990s. This allowed for an analysis of the relative cost distribution of health care services between a period of moderate restraint (the 1993/94 cohort of clients) and more severe restraint (the 1996/97 cohort).

The results indicate that there was a major resource shift from hospital services to home support services, while professional home care services remained relatively constant. Thus, for the 1993/94 cohort, the average annual cost of hospital care was \$13,416 for chronic care clients (47.5% of total annual health costs for home based clients) and the cost of home support services was \$10,381 (36.7% of total costs). For the 1996/97 cohort the comparable costs were \$9,458 for acute care and \$13,195 for home support, for a shift in relative costs of some \$3,000. Thus, more was spent on home support for the 1996/97 cohort and this amount represented a significant portion of the decrease in annual hospital costs between the two cohorts (see Table 4).

**Table 4: The Role of Home Support in Substituting for Acute Care Services for Home Based Clients (Extended Care Clients) in 1991/92 Dollars**

Type of Service	1993/94 Cohort		1996/97 Cohort	
	\$	%	\$	%
Physician Services	1,650.17	5.8	1,390.17	5.3
Hospital Services	13,415.73	47.5	9,458.38	36.0
Professional Home Care	1,658.79	5.9	1,233.34	4.7
Home Support	10,381.18	36.7	13,194.73	50.2
Other	1,152.83	4.1	992.61	3.8
Total	28,258.70	100	26,269.23	100

Source: Adapted from Hollander, M.J. (2001). *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services*. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care.

Further evidence of the cost-effectiveness of chronic home care, and particularly home support, is provided in a study of the cost-effectiveness of preventive home care. Hollander<sup>10</sup> conducted a study of a natural experiment which occurred in British Columbia in the 1994 to 1995 period in which some health regions cut people from care who were at the lowest level of care need and were only receiving housecleaning services, while some regions did not make such cuts. He studied the overall costs to the health care system of people who were cut from service in two health regions to people who were not cut from service in two similar regions. In the year before the cuts the average annual cost per client for those who were cut from service was \$5,052 and the cost per client for the comparison group was \$4,535. For the third year after the cuts were made the comparative costs were \$11,903 and \$7,808, respectively, for a net difference of some \$3,500 (see Table 5). Thus, on average, the people who were cut from care cost the health care system some \$3,500 more in the third year after the cuts than people who were not cut. Total costs over the three year period after the cuts were \$28,240 and \$20,543, respectively for those who were cut from care compared to those who were not cut.

**Table 5: Comparative Costs Per Person of Care Before and After Cuts for Health Regions With and Without Cuts**

		Period			
		Year Prior to Cuts	First Year After Cuts	Second Year After Cuts	Third Year After Cuts
<b>All costs</b>	Cuts	5,051.84	6,682.77	9,654.22	11,903.38
	No Cuts	4,535.02	5,963.10	6,771.45	7,807.96

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

In examining the data, it was found that most of this difference was accounted for by increased costs for acute care and long term residential care. Over the three years there was a net difference in hospital costs of some \$2,300 (i.e., an average additional costs of \$2,300 for people who were cut from care compared to those who were not cut) and residential long term care service costs of some \$3,200. Thus, the findings of the study clearly indicate that even basic home support services can have a significant impact on the cost-effectiveness of our health care system. While the reasons for increased costs could not be directly ascertained in the study, there was some anecdotal evidence to indicate that the findings are consistent with the following scenario. The people who were receiving cleaning services were not representative of the general population of elderly persons. They had been assessed by a health professional as needing government-funded services to enable them to remain independent. The assessment would have indicated that the clients needed cleaning to maintain a normal, sanitary home environment due to frailty or some other limiting condition. Thus, one can hypothesize that if these people were not able to pay for cleaning or did not have family members who could assist, or in some cases even if they did, they may have attempted to clean and vacuum by themselves. This may have led to an accident requiring hospitalization, or an increased deterioration in function which may have led to institutionalization.

While it is clear that further corroborating studies are needed, the Canadian evidence to date is sufficiently robust that the burden of proof now falls to those who would argue that chronic, long term, home care is not cost-effective. From the data presented above, one can make a plausible argument that long term home care has been, and can continue to be, a key component in increasing the overall efficiency and effectiveness of the Canadian health care system, and that home support services are an integral part of this form of home care.

### **Home Care in a Broader Continuing Care Context**

Hollander and Chappell<sup>11</sup> present a number of policy recommendations regarding home care. They note that home care, in order to more readily make the types of substitutions required to achieve greater effectiveness, needs to be part of a broader, integrated system of home care and residential care, often referred to as continuing care. By having administrative and fiscal control over such a large, integrated system of care senior executives and policy makers can take steps to ensure that appropriate substitutions of home care for acute care and residential care can, in fact, take place. They note that simply enhancing expenditures on home care *per se* may have a limited effect, unless steps are taken to ensure appropriate substitutions of home care services for acute and/or residential services. Thus, they recommend a shift in Canadian health care policy from a focus on home care on its own to a broader integrated model of continuing care in which cost-effective substitutions of home care for residential care can be facilitated.

It is generally not recognized by policy makers that a properly constructed continuing care system would, in terms of public expenditures, constitute the third largest component of the Canadian health care system after hospitals and medical services. By extrapolating data from the early 1990s, and using the little current data which does exist, Hollander<sup>12</sup> estimates current annual public expenditures on continuing care to be some \$11 to 13 billion,<sup>13</sup> which is more than current public expenditure on drugs (while Canadians spent some \$18 billion on drugs in 2002, only 36% or \$6.5 billion was paid for by government<sup>14</sup>).

In a study which takes the above theme further Hollander and Prince,<sup>15</sup> in a synthesis of a large national study, clearly present the current problems of lack of integration and systems fragmentation for health care delivery systems for seniors, persons with disabilities, persons with chronic mental health conditions, and children with special needs. These are all people who have ongoing, or long term, care needs. The authors found that there was a significant overlap in the care services required by these populations and problems related to the lack of integration in their respective care delivery systems. They go on to lay out a clear, best practices blueprint for how to organize an efficient and effective health care service delivery system for persons with ongoing care requirements. This is not a theoretical document. Their model simply extends, and/or combines, best practices for service delivery systems which currently exist, or have existed, in Canada. Thus, the model has a clear empirical basis in regard to an analysis of current problems, and builds on the best Canadian traditions in regard to service delivery systems for persons with ongoing care needs.

## **Resource Implications**

A final point to note is that some policy makers may have the misapprehension that focusing on chronic or long term care may significantly increase costs. In this regard it should be noted that all Provinces and Territories already have well developed, government funded, systems of long term home care. All jurisdictions already provide professional services free of charge. Some provinces such as Manitoba, Ontario and Québec provide home support services without charge under certain conditions. Most other provinces provide them on an income tested basis. Thus, the cost to “top up” existing systems could be fairly modest if one builds on the systems which already exist. In addition, restructuring resources into a continuing care model will not necessarily require new resources as the component parts of such a system are generally already in place in each jurisdiction in Canada.<sup>16</sup> Change costs would, however, be incurred. In terms of current expenditures on home care, they are generally about one third to one half of the costs of residential care, or approximately one quarter to one third of total continuing care costs,<sup>17</sup> although the proportions do vary from province to province.

The danger in focusing exclusively on short term home care is that the definition of home care will shift in the minds of policy makers and the public to equating home care with short term home care. This could lead to further encroachment on home care services, and particularly home support services, for people with ongoing care needs. This, in turn, could lead to a negative cost spiral in which home support funding is reduced and hospital funding is increased, leading to greater demands on acute and residential care services because people can no longer cope at home. This increased demand will then be used to justify further increases to institutional budgets resulting in further decreases to home support, leading to further rounds of increased demands on hospitals and long term care facilities, repeating the cycle over and over and increasing the overall costs of the Canadian health care system.

## **Conclusion**

In conclusion, we would argue that even modest investments in long term home care, and a revalidation of long term home care as an integral part of home care in Canada, are good strategic policy investments. The emerging evidence in Canada seems to support the potential for long term home care, including home support, to increase the overall cost-effectiveness of the Canadian health care system. As care delivery systems for persons with ongoing care needs are fragmented and less effective than they could be, it is also noted that cost-effective substitutions can be more readily made in a larger, integrated system of continuing care, of which home care is a part. Finally, a proposed solution now exists, which is well regarded by the sector delivering care services to persons with ongoing care needs.

Thus, we have evidence that long term home care, within an integrated model of care, has the potential to be a significant contributor to the increased efficiency and effectiveness of the Canadian health care system. We now also have a clear picture of the inefficiencies and fragmentation of existing care delivery systems and we have a well regarded solution for how to more optimally organize care delivery systems so that they can better contribute to increasing the efficiency, effectiveness and quality of the Canadian health care system. What is needed to

achieve this goal is the political will to shift the current policy on home care, and continuing care, and to take the appropriate actions to improve our health care system.

The above is particularly germane in light of the fact that similar policy positions were noted in a major policy document prepared by the Federal/Provincial/Territorial Subcommittee on Continuing Care over 10 years ago.<sup>18</sup> The document stated that future policy directions in this sector should focus on: adopting a broader, integrated systems perspective for continuing care services; adopting a healthy public policy perspective which integrates health services with social services such as housing; and providing comprehensive, flexible, holistic and appropriate services (including home support services). These policy directions, and a number of others which are also still relevant today, were noted over 10 years ago. What will the next 10 years bring? Will policy on continuing/community care continue to languish, or will policy makers become more actively engaged in improving health services for people with ongoing care needs (i.e., the most vulnerable people in our society)? Our research to date seems to indicate that, by increasing the effectiveness of care delivery, one can actually achieve what are often considered to be two irreconcilable goals, improving the quality of care *and* reducing the costs of health care.

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<sup>3</sup> Health Canada (2003) Health Care Renewal Accord 2003. 2003 Firsts Ministers' Accord on Health Care Renewal. Online at <http://www.hc-sc.gc.ca/english/hca2003/accord.html>.

<sup>4</sup> Hollander, M., & Chappell, N. (2002). *Final Report of the National Evaluation of the Cost-Effectiveness of Home Care*. Victoria, BC: Hollander Analytical Services Ltd. and the National Evaluation of the Cost-Effectiveness of Home Care.

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<sup>12</sup> Hollander, M. J., (2003). *Unfinished Business: A Framework for Organizing Health Care Delivery Systems for People with Ongoing Care Needs Across Canada*. Presented at the National Healthcare Leadership Conference, Edmonton, Alta, June 9-10.

<sup>13</sup> For example, total government expenditures for most continuing care services in British Columbia in the 1999/2000 fiscal year were \$1.23 billion. Extrapolating the figure to the current period, and across Canada, provides a number which is consistent with this estimate.

<sup>14</sup> Canadian Institute for Health Information. (2003). *Health Care in Canada*. Ottawa, Ontario: Canadian Institute for Health Information.

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<sup>17</sup> In British Columbia, in fiscal 1999/2000 total expenditures on continuing care services were \$1,232,990,117, home care expenditures were \$312 million and residential expenditures were \$921 million. Thus, home care and home support services accounted for 25.4% of all continuing care services and 33.9% compared to residential care. Comparable percentages for Alberta, Saskatchewan and Manitoba were 28.4% and 39.7%, 33.4% and 50.2%, and 24.1% and 31.6%, respectively (Hollander, M.J., Anderson, M., Béland, F., Havens, B., Keefe, J., Parent, K., & Ritter, R. (2000). *The Identification and Analysis of Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care* (Technical Report 5: An Overview of Continuing Care Services in Canada). Victoria, BC: Hollander Analytical Services Ltd.).

<sup>18</sup> Health and Welfare Canada. (1992). *Future Directions in Continuing Care*. Ottawa: Health Services and Promotion Branch

<sup>19</sup> Documents listed here which are published by the National Evaluation of the Cost-Effectiveness of Home Care and Hollander Analytical Services can be downloaded free of charge from: [www.homecarestudy.com](http://www.homecarestudy.com) and [www.hollanderanalytical.com](http://www.hollanderanalytical.com), respectively.