

**FEDERAL-PROVINCIAL-TERRITORIAL  
ADVISORY COMMITTEE ON HEALTH SERVICES (ACHS)  
WORKING GROUP ON CONTINUING CARE**

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**The Identification and Analysis of Incentives  
and Disincentives and Cost-Effectiveness of  
Various Funding Approaches for Continuing Care**

**Final Report**

**May 2000**

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**The Identification and Analysis of Incentives  
and Disincentives and Cost-Effectiveness of  
Various Funding Approaches for Continuing Care**

**Final Report**

**Prepared by:**

**Project Team:**

**Dr. Marcus Hollander (Project Leader)  
Dr. Malcolm Anderson  
Dr. François Béland  
Dr. Betty Havens  
Dr. Janice Keefe  
William (Bill) Lawrence  
Karen Parent  
Richard Ritter**

**Project Advisors:**

**Dr. Neena Chappell  
Dr. Peter Coyte  
Dr. Raisa Deber  
Dr. Philip Jacobs  
Dr. Robert (Bob) Modrow  
Dr. Evelyn Shapiro**

**May 2000**



**Hollander Analytical Services Ltd.  
308 – 895 Fort Street  
Victoria, BC, V8W 1H7**

**Tel: (250) 384-2776  
Fax: (250) 389-0105  
info@hollanderanalytical.com**

## **EXECUTIVE SUMMARY**

### **Introduction**

This report provides the findings and policy implications of the project on financial incentives and disincentives in continuing care. Several sub-initiatives were undertaken as part of this project. An extensive international literature review was conducted on funding systems in continuing care. Government and industry representatives were interviewed using a twenty question interview schedule. In addition, each jurisdiction was asked to complete a series of data tables related to the organization, utilization and financing of continuing care services. In order to obtain more in-depth information on topics of particular interest to the Federal/Provincial/Territorial Advisory Committee on Health Services (ACHS), three case studies were conducted on the topics of the public/private mix, the hospital and home care interface, and decision making under constraint.

### **Overview of Continuing Care**

The *Canada Health Act*, passed in 1984, sets out two major categories of service, Insured Health Services (IHS) and Extended Health Care Services (EHCS). Insured Health Services include hospital care (acute and chronic) and services provided by physicians and are covered, as insured services, by the five principles of the Act. Extended Health Care Services include nursing homes or long term residential care, home care, adult residential care, and ambulatory health care services and are not insured services. Therefore, they do not come under the five principles of the Act. Other continuing care services such as homemaker services and adult day care are not covered by the *Canada Health Act*. They were formerly cost-shared through the Canada Assistance Plan (CAP) and now come under the general transfer provisions of the Canada Health and Social Transfer (CHST). Given the historical evolution of continuing care in each jurisdiction, Canadian provinces and territories developed different models of how to provide continuing care services, and different terms and conditions for the provision of services. Thus, while there are core services which are generally considered to be part of continuing care in all jurisdictions, there is also some variation across jurisdictions regarding which other services are, or are not, included in continuing care.

### **Key Concepts and Definitions Related to Funding Continuing Care Services**

There are four key terms which are used in this report to refer to the constellation of activities by which payers provide payments to service providers. The first term *funding* is used as a broad and generic term for this area and can refer to any or all of the three following terms: financing, resource allocation, and reimbursement.

The term *financing* refers to the mechanisms by which payers pay for health services received or for the health service delivery system. There are three forms of financing: the first is the direct payment by the payer to an individual or organization, typically, for services rendered; the second is payment through the tax system; and the third is private insurance.

The term *resource allocation* refers to the way in which fiscal intermediaries (Ministries of Health, insurance companies) allocate an envelope of dollars for a given geographic area or type of

service. The term *reimbursement* refers to the actual method, or formula, used to provide dollars to an individual service provider or service provider organization.

Table 1 presents a typology of the major models of reimbursement used in health services. It consists of two key dimensions: scope and the basis for payment. Scope refers to whether funds flow to individual providers (e.g., physicians) or to organizations (e.g., single institutions such as hospitals or multi-service organizations such as regional boards or integrated health systems). Regarding the basis of payment, reimbursement models can be based on a number of factors, including the costs incurred, time spent, services delivered, population served, and outcomes achieved.

**Table 1: Scope and Basis of Payment for Funding Models**

Scope	Basis of Payment				
	Cost	Time Spent	Services Delivered	Population Served	Outcomes
Individual	<ul style="list-style-type: none"> <li>• Cost Plus (e.g., Drug Benefits)</li> </ul>	<ul style="list-style-type: none"> <li>• Salary</li> <li>• Sessional</li> <li>• Per Hour</li> </ul>	<ul style="list-style-type: none"> <li>• Fee-For-Service</li> <li>• Payment per Task</li> <li>• Payment per Visit</li> </ul>		
Organization	<ul style="list-style-type: none"> <li>• Line-By-Line Budget Models (e.g., LTC Facilities, Adult Day Services)</li> <li>• Average Cost Models (e.g., LTC Facilities, Adult Day Services)</li> <li>• Global Budgets (e.g., LTC Facilities and Hospitals)</li> </ul>	<ul style="list-style-type: none"> <li>• Per Diem</li> <li>• Per Hour (e.g., Home-Makers)</li> </ul>	<ul style="list-style-type: none"> <li>• Fee-For-Service</li> <li>• Payment Per Task</li> <li>• Payment Per Visit (e.g., Home-Nursing)</li> <li>• Diagnosis Related Groups (DRG, CMG, RIW)</li> <li>• Other Rate Based Case-Mix Models (e.g., RUG Funding for LTC Facilities)</li> </ul>	<ul style="list-style-type: none"> <li>• Capitation (e.g., Regional Funding Models)</li> <li>• Budget Per Catchment Area</li> </ul>	<ul style="list-style-type: none"> <li>• Performance Contracting</li> </ul>

In Canada all jurisdictions have some form of co-payment for residential care. In most jurisdictions some form of room and board equivalent cost is used so that clients typically only pay about one-quarter to one-half of the overall cost of care. There are generally no, or low, co-payments for home nursing services and community rehabilitation services such as physiotherapy and occupational therapy (PT/OT). Homemaker services are provided without a co-payment in a few jurisdictions but in most jurisdictions an income test is applied and clients, depending on their means, may have to pay up to the full cost of care. Most other home and community services also have some form of co-payment. Depending on the jurisdiction, there may be a lesser or greater subsidization of drug costs for seniors. There is a general funding anomaly in home care such that drugs, equipment, and supplies such as dressings are provided free of charge in hospitals but may have to be purchased by individuals when they leave the hospital.

Governments and regional boards can adopt at least two responses to dealing with service providers. One is to be a partner with the health care organizations they oversee and to take on joint responsibility, and accountability, with providers about the cost and quality of health services. The other approach is to devolve responsibility to health providers and take on the role of an efficient purchaser of services in a more market oriented model. One can also apply this concept of the partnership versus market model to models of reimbursement. In order to be effective, models of reimbursement should be congruent with larger issues such as government philosophy, the policy stance of Ministries of Health and the structural approaches to service delivery.

### **Common Reimbursement Models in Continuing Care in Canada**

The retrospective budget model, which is used in many parts of Canada to fund long term care facilities, is a model in which a draft budget is prepared based on expenditures in the previous year plus an inflation factor and any agreed upon adjustments. Funds are expended and deficits are covered at the end of the year. Surpluses are either recovered or applied against the budget for the following year. One can maintain greater control over quality in a budget based model but there is a danger of costs increasing at a greater rate than may be the case for other models of reimbursement. It has been noted, however, that by good bargaining and judicious use of pressure it is possible to limit budget increases. It is possible to shift some further fiscal responsibility to facilities by adopting global budgets, or by using floors, ceilings and/or averages for parts of the budget over which management of the facility has some control.

Payment by hour or visit is the most common model of funding for home care services. The incentive for the provider is to do more, but shorter, visits if funding is provided on a per visit basis. Per hour and per visit funding do not have built in incentives to teach clients to care for themselves. Some agencies may also go over their annual allocations and argue client need in order to be awarded more hours/visits in subsequent years. Unless there are very tight caps on the amount of service which can be provided, this model can provide enough care and there are no major pressures to reduce the quality of care. Thus, both for this model and the budget model, there may be pressure for cost increases but agencies can maintain the volume and quality of services agreed to with the funder. Once service is purchased primarily on price, issues of labour relations and the quality of service begin to emerge.

The move to tendering for home care services in some regions is an interesting development. The experience in the literature indicates that tendering will tend to drive out not-for-profit providers. There are also different dynamics if tendering is done for all agencies on a regular (e.g., annual) basis or if one only re-tenders for new services. Regular tendering may allow previously unsuccessful agencies which have reduced costs and/or increased quality to come back into the market. It also allows new low-cost agencies into the market, thus keeping prices low.

Case mix funding provides a closer fit between the care needs of clients and the funding provided. Without case mix adjustment, facilities have an incentive to admit low care level clients who may not need to be in facilities and this, in turn, may inhibit entry for clients with higher care needs. There are generally three approaches to case mix funding in care facilities. Case mix adjustments can be imbedded into a budget or global model of funding. One can also fund facilities

using an average case mix score for the facility or by having specific per diem rates for each level of care. There are some possibilities for gaming by “charting for dollars” if client classification data are collected from charts or if facility staff are used to assign care levels. This is why in most jurisdictions government staff or independent agencies are used to manage client care for the overall continuing care system and to assign care levels.

### **Findings Related to the Public/Private Mix**

Publicly delivered services are generally understood to be services provided by federal, provincial and territorial governments. Some services are also provided by municipal governments. Private services are generally understood to be services provided by not-for-profit organizations or by for-profit organizations.

Findings from this report, and other studies, have revealed that for home care many jurisdictions have no user fees for professional services but have user fees, based on an income/asset test, for homemaker and care aid services. This reflects both historical and philosophical traditions. Historically, home care nurses and rehabilitation specialists were seen to be part of the “health” system. Thus, such services have generally been provided without a fee. Homemakers, care aids and many other services included in continuing care come from social services where there were generally income tests.

A related issue for facility care is the anomaly that in Atlantic Canada people who are admitted to long term care facilities are income/asset tested and if they have sufficient funds may have to pay up to the full cost of care. Thus, they pay the room and board, and care, portions of the cost. Clients in the rest of Canada may still be income tested but are only required to pay what amounts to a room and board portion (costs they would have to pay if they lived at home, about \$20 to \$50 per day) and the state pays for the care portion of costs.

The case study on the public/private mix reflected the tension noted above. There has always been a public/private mix in continuing care. However, the question is whether the trend is to greater private payment, and/or private delivery, or whether this trend will be reversed, perhaps through the infusion of additional funding from the federal government.

### **Findings Related to the Hospital and Home Care Interface**

As was noted in case study two on the hospital and home care interface there is increasing pressure to expand the availability of home care services. Making home care available seven days per week and 24 hours per day will take many adjustments and conscious policy choices. The pressure for such action is growing as the proportion of clients receiving short term, post-acute home care increases due to pressures for greater efficiency in hospitals.

The international literature is mixed and there are relatively few Canadian studies on the cost-effectiveness of home care as a substitute for acute care. While the findings in case study two on the hospital to home care interface are clearly tentative they do seem to lend some support to the contention that home care can be an effective alternative to acute care services.

An analysis of the findings in case study two reveals what may be key elements for a successful hospital to home care program. These are:

- The Board and senior management have to exhibit vision, leadership and commitment to the initiative. This is probably a critical success factor.
- There should be some degree of separation in how funds are shifted between hospitals and home care. If the transfer is too direct and people lose jobs as part of the transfer there may be ill will that can linger for a long time.
- Transitional beds may be a useful component of a hospital to home care initiative because they allow people to recover to the point where they can go home instead of to a long term care facility.
- Developing initiatives on a direct cost recovery basis may cause some problems. It is also a questionable option in that other sectors of the health system, such as hospitals, generally do not have to justify new investments.
- Services are connected in an overall system of health care. Thus, one should consider whether proposed changes to acute care services may have a negative effect on continuing care services before any such changes are implemented.
- Effective discharge planning is a key to the effective transfer of clients from the hospital to continuing care services.
- Finally, it is a good idea to involve physicians actively and from the beginning of the initiative. They have a great deal of influence about how and when clients can move from the hospital back to their homes. There may be some benefit to a greater involvement of physicians in home care.

### **Findings Related to Decision Making under Constraint**

An important finding of case study three, on decision making under constraint, is the extent to which external factors affect allocation choices at the front lines. Analysis of case study three revealed that decisions are directly influenced by macro-contextual factors including both fiscal and demographic imperatives. The system is being pressured by reduced hospital stays, clients with a higher level of acuity, capped budgets and issues surrounding the recruitment and retention of staff. Coupled with these macroeconomic issues are other indirect influencing factors including the historical underpinnings of the home care program, organizational values, variations in the educational backgrounds of case managers, length of service of case managers, and the desires of the client and his or her family. These direct and indirect factors influence management and staff to respond or "cope" by:

- Prioritizing
- Working outside convention
- Building community
- Finding innovative ways to meet the need (negotiating and gaming).

## **Lessons Learned and Key Policy Issues for Consideration**

In the work done for this project a number of specific lessons were learned about what senior management and decision makers can do to improve care. These are:

- Focus on the unmet needs of clients and give them a very high priority.
- Be more open to innovation and experimentation.
- Balance clinical and financial aspects, do not allow case managers to become primarily fiscal policeman.
- Be clear about guiding values and principles.

## **Proposed Guidelines for Selecting Funding Models**

When one is considering how to fund continuing care services it may be useful to keep in mind the following general guidelines:

- Funding mechanisms should be congruent with fiscal and program goals.
- Funding mechanisms should be structured in a way that provides a balance between price and quality.
- Funding mechanisms should be consistent with the larger policy goals and directions of Ministries of Health and Regional Health Authorities.
- Funding mechanisms between different sectors of the health system should complement each other and provide incentives, rather than disincentives, for greater service integration.

## **Key Policy Issues**

There are numerous implications for policy from the findings of this project. The following presents four major policy issues that emerged from this study.

- **Information Systems:** There are data gaps in existing information systems and there is no national reporting system for home care. Many of the tools needed to address these shortcomings have recently been developed. It is now a policy choice as to whether we adopt similar data collection instruments across Canada, or not.
- **Current Inequities:** Drugs and other items are currently provided without co-payments for individuals in hospitals but co-payments may be required once a client leaves the hospital. There is also an inequity in facility care in that in Atlantic Canada those with sufficient resources may have to pay for the full cost of care while clients in the rest of Canada may only pay for the “room and board” portion of care in a facility. Finally, there are also differences in the degree to which continuing care services are portable across jurisdictions. Decision makers may wish to consider these inequities.

- **User Fees in Home Care:** Policy makers may wish to consider the differences noted in this report regarding user fees for professional home care services and home support services. Both types of care are needed by clients to allow them to remain at home and, potentially, to prevent institutionalization. Is it still necessary to maintain this difference or can steps be taken to make home support services universal services provided without user fees?
- **Strain on the System:** While it is recognized that money is not the only solution, and that steps should be taken to increase efficiencies, the continuing care system seems to be under strain. This would seem to indicate that it may be time to consider what would constitute an appropriate funding level for this sector.

## **PREFACE**

This was a large and complex project with many different aspects. In order to complete the project, a fairly large project team was assembled to conduct the work. Some members of the team actually conducted portions of the work while others served in more of an advisory capacity. Everyone involved in this project played an important part and is to be commended for their hard work and dedication. The investigators for this project were:

### **Project Team:**

**Dr. Malcolm Anderson**

Associate Director, Research, Queen's Health Policy Research Unit  
Queen's University

**Dr. François Béland**

Professeur, Département d'administration de la santé  
Université de Montréal

**Dr. Betty Havens**

Professor and Senior Scholar, Department of Community Health Sciences  
University of Manitoba

**Dr. Janice Keefe**

Associate Professor, Department of Family Studies and Gerontology  
Mount St. Vincent University

**William (Bill) Lawrence**

Associate, Hollander Analytical Services Ltd.

**Karen Parent**

Senior Research Associate, Queen's Health Policy Research Unit  
Queen's University

**Richard Ritter**

Associate, Hollander Analytical Services Ltd.

**Project Advisors:**

**Dr. Neena Chappell**

Director, Centre on Aging and Professor of Sociology  
University of Victoria

**Dr. Peter Coyte**

Professor of Health Economics, Department of Health Administration  
University of Toronto

**Dr. Raisa Deber**

Professor, Department of Health Administration  
University of Toronto

**Dr. Philip Jacobs**

Professor, Department of Public Health Sciences  
University of Alberta

**Dr. Robert (Bob) Modrow**

Head, Division of Health Policy and Management, Faculty of Medicine  
University of British Columbia

**Dr. Evelyn Shapiro**

Professor, Department of Community Health Sciences  
University of Manitoba

**Marcus J. Hollander, PhD**

Project Leader, and  
President, Hollander Analytical Services Ltd.

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## 1. INTRODUCTION <sup>1</sup>

In order to bring a more concerted policy focus to continuing care, the Federal/Provincial/Territorial (F/P/T) Ministers of Health set future priorities for work related to “supporting high quality integrated acute, continuing and community-based health services” at their meeting in September 1998. As a response to these priorities, a work plan was developed by the F/P/T Working Group on Continuing Care (WGCC) which included this project on financial incentives and disincentives within the continuing care sector. The WGCC work plan was approved by the F/P/T Advisory Committee on Health Services (ACHS) in November 1998, and a competitive bidding process was conducted for the project. The project was launched in September 1999 and project activities were overseen by a Project Advisory Committee (PAC) made up of members of the WGCC.

As noted in the Request for Proposal, the specific goals or purposes of this project were as follows:

- Document the current situation with respect to continuing care budgets, client coverage/entitlements, and the public/private mix;
- Identify intended and unintended incentives and disincentives both within continuing care and operating elsewhere in the health system but impacting on continuing care services, and analyze the effects of these incentives/disincentives on actual service delivery and cost-effectiveness;
- Produce selected case studies which compare, for example, different funding approaches relative to similar clusters of services, or different coverage/entitlements and service mix for certain client groups (e.g., elderly, clients with complex needs), or the cost-effectiveness of care in hospitals versus the community.

With regard to the third goal noted above, case studies were conducted for this project on the public/private mix, funding mechanisms to facilitate the hospital and home care interface, and decision making processes related to allocating continuing care resources, under constraints.

This report provides the findings and policy implications of the project on financial incentives and disincentives in continuing care. Chapter two provides a brief overview of the methods used for this project. Chapters three and four provide an overview of continuing care and key concepts and definitions related to funding. Chapter five provides a typology of funding models and a discussion of the incentives and disincentives inherent in each model. Chapter six provides an overview of the national consultation portion of this project, while chapter seven provides a discussion of findings related to the funding of continuing care services in Canada. Chapters eight to ten provide overviews of findings related to the public/private mix, the hospital and home care interface, and decision making under constraint. Chapter eleven presents the key lessons learned in this study, proposed guidelines for selecting appropriate funding models, and key policy issues for consideration.

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<sup>1</sup> This final report constitutes a summary of project findings. For more detailed information the interested reader is referred to the Technical Reports of this project.

## 2. METHODS

There were several sub-initiatives which were undertaken as part of this project. An extensive international **literature review** was conducted on funding systems in continuing care. Two initiatives were undertaken with provincial and territorial officials to obtain information. These initiatives are jointly referred to as the **national consultation**. Key officials were contacted by the project team in each province and territory. A twenty question interview schedule was used to guide the discussion with officials. In addition, each jurisdiction was asked to complete a series of data tables on key elements related to the organization, utilization and financing of continuing care services. As well as these two initiatives, an **industry consultation** was conducted with some 30 leaders in the continuing care industry across Canada.

In order to obtain more in-depth information on topics of particular interest to the F/P/T ACHS three **case studies** were conducted on the topics of the public/private mix, the hospital and home care interface, and decision making under constraint. All of the material collected served as the basis for the discussion of findings in this report. For more detailed information on all of the above initiatives, the interested reader is referred to the Technical Reports of this project.

## 3. AN OVERVIEW OF CONTINUING CARE

The *Canada Health Act*, passed in 1984, sets out two major categories of service, Insured Health Services (IHS) and Extended Health Care Services (EHCS). Insured Health Services include hospital care (acute and chronic) and services provided by physicians. In the Act, the five principles of the Canadian health care system (universality, accessibility, comprehensiveness, portability, and public administration) and the restrictions on user fees and extra-billing apply to Insured Health Services. Extended Health Care Services include nursing homes or long term residential care, home care, adult residential care, and ambulatory health care services and are not insured services. Therefore, they do not come under the five principles of the Act. Other continuing care services such as homemaker services and adult day care are not covered by the *Canada Health Act*. They were cost-shared through the Canada Assistance Plan (CAP) and now come under the general transfer provisions of the Canada Health and Social Transfer (CHST). Given the historical evolution of continuing care in each jurisdiction, Canadian provinces and territories developed different models of how to provide continuing care services, and different terms and conditions for the provision of services. Thus, while there are core services which are generally considered to be part of continuing care in all jurisdictions, there is also some variation across jurisdictions regarding which other services are, or are not, included in continuing care. The overall definition of continuing care for the purposes of this project was as follows:

*Continuing care* is a term that is generally used to describe a system of service delivery which includes all of the services provided by Long Term Care, Home Care and Home Support. This term reflects within it two complementary concepts: that care may “continue” over a long period of time, and that an integrated program of care “continues” across service components, that is, that there is a continuum of care from community services such as Meals-on-Wheels to care in geriatric units in acute care hospitals. . . . This system of service delivery has a number of components and is integrated through a “continuum of care.”<sup>2</sup>

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<sup>2</sup> Hollander, M.J. and Walker, E. (1998). *Report of continuing care organizations and terminology*. Ottawa: Health Canada.

Continuing care continues to evolve and there is considerable lack of clarity with regard to key terms. Four umbrella terms which have been used to describe systems of service delivery require clarification: *continuing care*, *long term care*, *home support*, and *home care*. *Continuing care* is a term which is generally used to describe a system of service delivery which includes all of the services provided by long term care, home support and home care. In some jurisdictions, the term *continuing care* has now come to represent more of a concept or an organizing paradigm than an administrative reality.

Historically, a distinction was sometimes made such that the term *long term care* was used to describe a range of institutional services, primarily for the care of the elderly, and the term *home care* was used to describe home based services provided primarily by nurses and other professionals such as physiotherapists.

The term *long term care* also has a second, very different meaning. This term has come to refer to both residential and community based services and has come to have a meaning similar to the term *continuing care*. This usage is currently the norm in Ontario. This definition includes residential long term care services, community and home based long term care services, that is, home support and longer-term home care services. While not in the definition *per se*, short term home care is also often included within the range of services covered by this usage of the term *long term care*.

Home and community based long term care services, generally provided by non-professional staff such as homemakers, rather than by professionals such as nurses or rehabilitation therapists, are often referred to as *home support* services, even though some of these services are provided in the community. Adult day care and group home services are community based *home support* services.

There are three distinct functions of *home care*: the acute care substitution function, the long term care substitution function, and the maintenance and preventive function. **For the purposes of this study, the term *home care* will be used to refer to all home and community based home support and home care services.** Organizational arrangements in the continuing care sector continue to be in a state of flux. Most provinces and regional health authorities are reviewing the way such services are organized, and changes continue to be made.

#### **4. KEY CONCEPTS AND DEFINITIONS RELATED TO FUNDING AND SERVICE DELIVERY**<sup>3</sup>

There are four key terms which will be used in this report to refer to the constellation of activities by which payers provide payments to service providers. The first term *funding* will be used as a broad and generic term for this area and can refer to any or all of the three following terms: financing, resource allocation, and reimbursement.

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<sup>3</sup> Parts of Chapters 4, 5 and 7 of this report are adapted from materials in the report by M. Hollander, R. Deber and P. Jacobs (1998). *A critical review of models of resource allocation and reimbursement in health care: A report prepared for the Ontario Ministry of Health*. Ottawa: Canadian Policy Research Networks (CPRN).

The term *financing* refers to the mechanisms by which payers pay for health services received or for the health service delivery system. There are three forms of financing; the first is the direct payment by the payer to an individual or organization, typically, for services rendered. The second and third methods are less direct. In the second method the payer pays for health services through the tax system. This is the model in place in Canada. The third method is to have the payer pay insurance premiums to an insurance company which is responsible for ensuring that the payer receives the services for which he or she is covered under the health insurance plan.

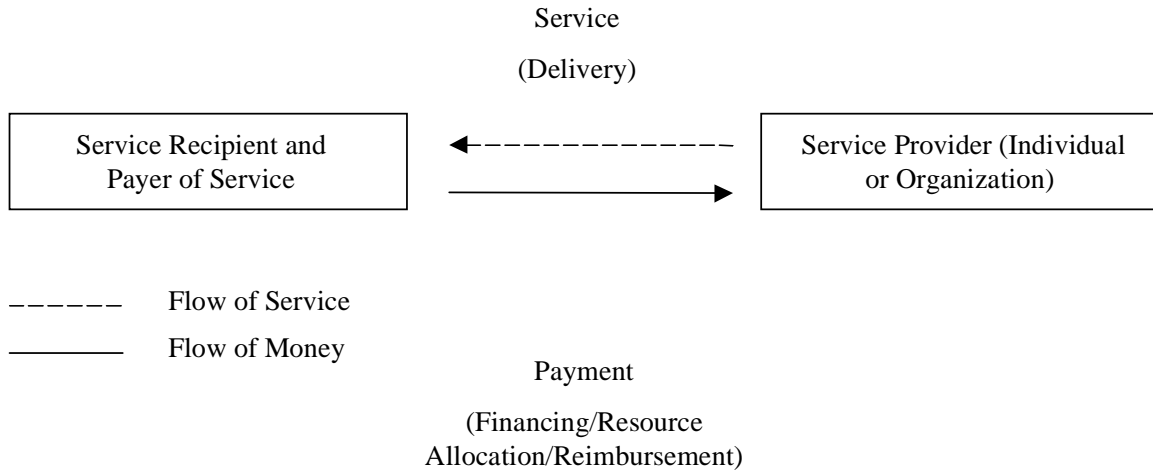
The term *resource allocation* refers to the way in which fiscal intermediaries (Ministries of Health, insurance companies) allocate an envelope of dollars for a given geographic area or type of service. The term *reimbursement* refers to the actual method, or formula, used to provide dollars to an individual service provider or service provider organization. While reimbursement for continuing care services was the primary focus of this project, some discussion of financing and resource allocation is also provided in this report.

There is an interrelationship between models of financing, resource allocation and reimbursement and the way health care delivery systems are organized. In the simplest model of service delivery, there are only two parties: the payer who is also the recipient of services and the service provider (either an individual such as a physician or an organization such as a hospital, home care agency or long term care facility). The relationship is a simple one, as shown in Figure 4-1. In this model, there is a flow of services from the provider to the client (delivery) and a flow of funds from the client to the provider (financing, resource allocation, and reimbursement).

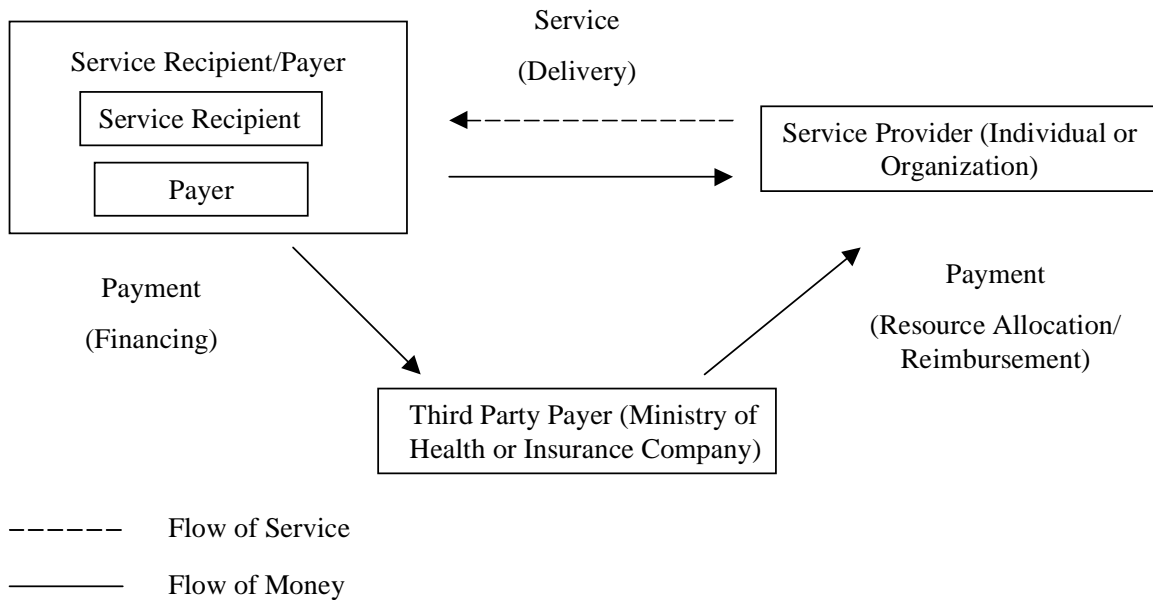
Although health systems may retain some role for direct payment for some services by the service recipient, the unpredictable nature of health care expenditures has led to the rise of third-party payers. In this model, individuals in effect purchase insurance, either from a private insurer or by paying taxes to government. In turn, the third-party payer (that is, the insurance company or Ministry of Health) flows the payments to the service provider(s). This relationship is depicted in Figure 4-2. The delivery flow (from providers to clients) remains the same; however, while payers and service recipients are generally the same, payment is separated from the direct receipt of services. *Financing* now refers to the flow of resources from actual and potential service recipients to the third-party payer(s); this flow can be in the form of insurance premiums or taxes. *Resource allocation/reimbursement* refers to the flow of resources from the third-party payer to the service provider(s).

A recent development is the emergence of multi-service organizations such as regional health authorities (RHA), integrated health systems (IHS), and primary care systems which cover a wider array of services. Whereas hospitals are paid only to provide acute care, or nursing homes only to provide residential long term care, regional bodies or integrated health systems are provider organizations that deliver a wider range of care. An important feature of these models is that the third party payer(s) can flow a specific sum of money to these organizations in exchange for an agreement that a specified array of services be provided to a specified population of potential care recipients. In turn, the intermediary organization can make its own arrangements with providers. For example, a regional health authority may be reimbursed on a capitation basis but may choose to pay some or all of those providing the care on a salary or fee-for-service basis. Figure 4-3 combines all of these elements. The system now allows for six types of payment flows to providers: flows of funds from service recipients to individual or single agency

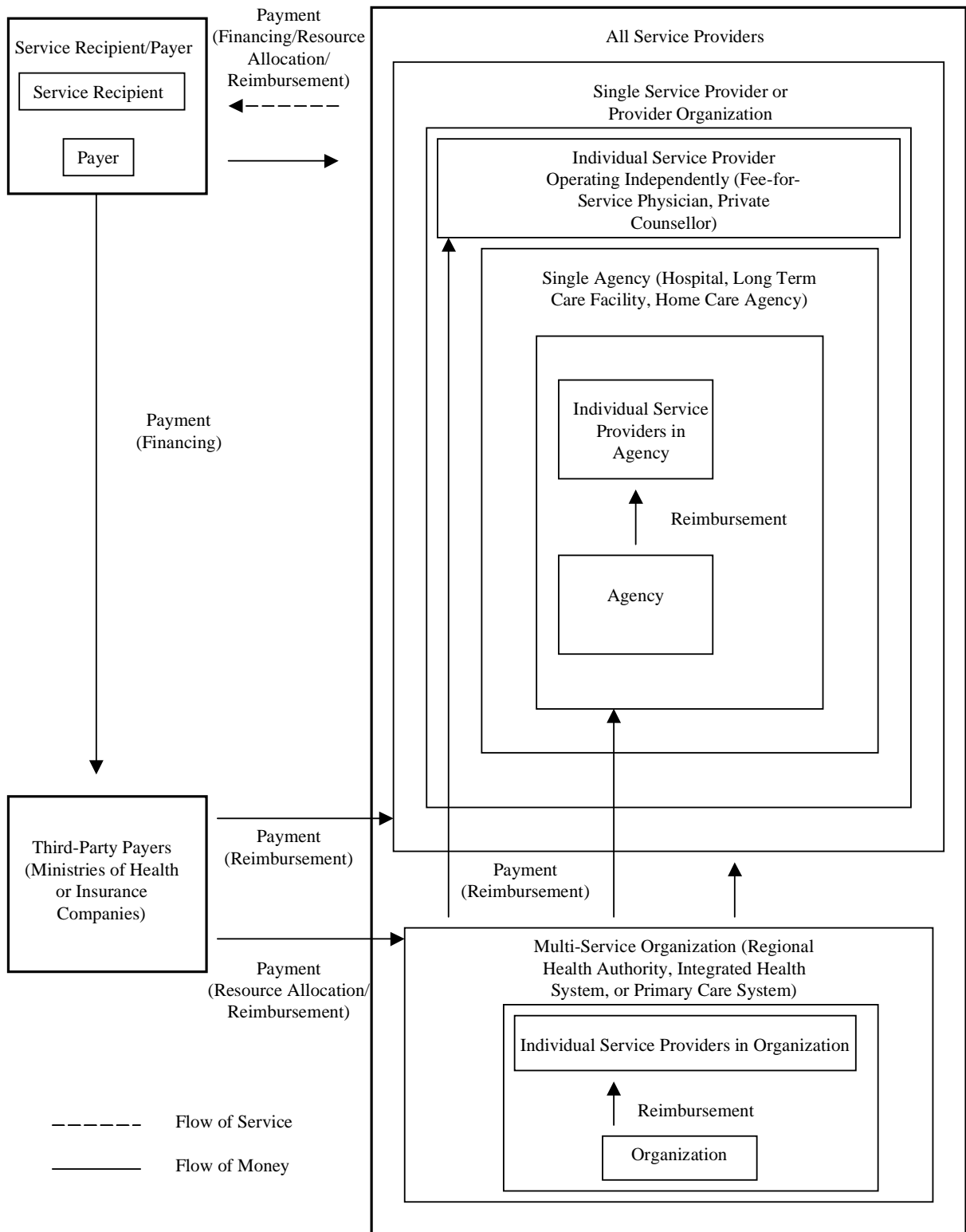
**Figure 4-1: Service and Payment Flows to Two Parties**



**Figure 4-2: Service and Payment Flows to Three Parties**



**Figure 4-3: Service and Payment Flows for Multiple Parties**



providers, flows from service recipients to multi-service organizations, flows from service recipients to third-party payers (e.g., Ministries of Health or insurance companies), flows from third-party payers to individual or single agency providers, flows from third-party payers to multi-service organizations, and flows from multi-service organizations (e.g., RHA, IHS, Primary Care System) to individual or single agency providers. Service recipients can, in turn, receive services from individual service providers, single service provider agencies, or multi-service organizations.

In terms of funding the above noted service providers, Table 4-1 presents a typology of the major models of reimbursement used in health services. It consists of two key dimensions: scope and the basis for payment. Scope refers to whether funds flow to individual providers (e.g., physicians) or to organizations (e.g., single institutions such as hospitals or multi-service organizations such as regional boards or integrated delivery systems). Regarding the basis of payment, reimbursement models can be based on a number of factors, including the costs incurred, time spent, services delivered, population served, and outcomes achieved.

**Table 4-1: Scope and Basis of Payment for Funding Models**

Scope	Basis of Payment				
	Cost	Time Spent	Services Delivered	Population Served	Outcomes
Individual	<ul style="list-style-type: none"> <li>• Cost Plus (e.g., Drug Benefits)</li> </ul>	<ul style="list-style-type: none"> <li>• Salary</li> <li>• Sessional</li> <li>• Per Hour</li> </ul>	<ul style="list-style-type: none"> <li>• Fee-For-Service</li> <li>• Payment per Task</li> <li>• Payment per Visit</li> </ul>		
Organization	<ul style="list-style-type: none"> <li>• Line-By-Line Budget Models (e.g., LTC Facilities, Adult Day Services)</li> <li>• Average Cost Models (e.g., LTC Facilities, Adult Day Services)</li> <li>• Global Budgets (e.g., LTC Facilities and Hospitals)</li> </ul>	<ul style="list-style-type: none"> <li>• Per Diem</li> <li>• Per Hour (e.g., Home-Makers)</li> </ul>	<ul style="list-style-type: none"> <li>• Fee-For-Service</li> <li>• Payment Per Task</li> <li>• Payment Per Visit (e.g., Home-Nursing)</li> <li>• Diagnosis Related Groups (DRG, CMG, RIW)</li> <li>• Other Rate Based Case-Mix Models (e.g., RUG Funding for LTC Facilities)</li> </ul>	<ul style="list-style-type: none"> <li>• Capitation (e.g., Regional Funding Models)</li> <li>• Budget Per Catchment Area</li> </ul>	<ul style="list-style-type: none"> <li>• Performance Contracting</li> </ul>

- Note: LTC – Long Term Care  
 DRG – Diagnosis Related Groups  
 CMG – Case Mix Groups  
 RIW – Resource Intensity Weights  
 RUG – Resource Utilization Groups

## **5. FUNDING MODELS AND THEIR INCENTIVES AND DISINCENTIVES**

### **5.1 Incentives and Disincentives**

In terms of the individual provider, there are a number of possible funding approaches. For funding based on costs, providers can be reimbursed on a cost plus basis such as is the case with some drug benefits programs. In this model there is little incentive to reduce costs and there is generally no sharing of risk as providers simply obtain a mark up on costs. The incentive in this model, for the provider, is to argue for higher mark-ups. There are now some programs in Canada that provide direct funding to clients to purchase their own care. This would also be an example of a cost based model of funding to individuals. In this case the individual is the care recipient and there would be no specific mark-up on the costs of purchasing the service(s) needed by the client, although some additional funding may be provided for administrative matters such as costs associated with purchasing and/or managing the care provider who was hired and documenting expenses.

In the cost plus model cost pressures can be mitigated by hard bargaining to restrain the percentage mark up that is used. Another approach may be to have funders assist in the bulk purchase of goods and/or services, across a range of providers, to reduce costs.

With regard to funding based on time spent, one common method of funding is to pay staff on a salaried basis. Individual providers, such as physicians, provide services on a sessional basis, and some providers can also be paid on an hourly rate. There are both advantages and disadvantages to payment based on time spent. There does not appear to be an incentive to provide services more efficiently or to provide better service as providers are paid only for the time they work. Greater efficiencies or better quality services can be derived from setting standards in the workplace but improvements are essentially the outcome of management, organizational culture, human resources policies and so on, rather than of the method of funding *per se*.

In a fee-for-service system, payments are made according to standard fee schedules, irrespective of the expenditure patterns of any given provider. This model provides for good access to care and, perhaps, over-serving. It is generally criticized on the basis that providers have an incentive to process as many persons as quickly as possible as they are paid on a per-service basis. To mitigate against these possibilities funders may wish to bargain hard to keep fee schedule increases low and to put into place care standards to ensure that providers provide adequate care.

Typically, population based models are not applied to individual practitioners, but rather to provider organizations. There are generally very few models of funding based on outcomes, and it is not clear to what extent such funding would be appropriate for individual providers.

In terms of service provider agencies, a common approach to funding is some version of line-by-line budgeting (e.g., long term care facilities, adult day services, and many other services). Line items can be aggregated and/or capped and there are many possible variations. Budget models are generally simple and easy to implement. The basic incentive for the provider is to obtain more money from the funder. In some cases global budgets have been constructed from previous historical expenditure patterns, i.e., they have their origins in a line-by-line model. With global budgets the providers do have more freedom to transfer funds between organizational components. Cost based funding for service provider agencies can

also be based on averages and ranges for major budget categories. One can mitigate against large cost increases by good bargaining, bulk purchase arrangements and a clear willingness not to purchase services from high cost providers. Another approach is to establish a sector based bargaining organization that deals with contracts and other labour relations matters on behalf of the employers of third-party agencies. This avoids setting precedents if one or two agencies give staff high salary increases because the collective interests of all employers are represented at the bargaining table.

In terms of payment for time spent, some agencies may charge for staff services on an hourly basis (e.g., homemaker services) or a per diem basis (e.g., live-in care attendants). These rates could be negotiated with government and/or be the outcome of a budget process. Alternatively, agencies could set their own rates based on their unique set of expenses, and purchasers could choose to buy, or not buy, services at those rates. There is fairly easy entry to the home care market place and funders can encourage new entrants in order to maintain a reasonable cost base.

In terms of payment for services provided, fee-for-service type models can apply to organizations as well as individuals. Perhaps the most well known model in this category is the American Diagnosis Related Group (DRG). The DRG model is one in which a flat rate is paid per visit to the hospital for each type of medical condition. There are often no modifiers to aid in the transition from a budget based model to one based on fixed fees for services delivered. This may cause problems in implementing a DRG type system, particularly if unit costs vary considerably across agencies. In addition, the incentive under a DRG model is for hospitals to process people as quickly as possible. In Canadian hospitals, Case Mix Groups (CMG) and/or Resource Intensity Weights (RIW) may be used to standardize for case mix, often within a broader global budget process. Similarly, models for funding long term care facilities may contain a case-mix component. These case-mix formulas can be used as the primary focus of reimbursement such as the DRG approach or can be used to adjust budget based, global or other models of funding. Industry representatives noted that in Canada the push has been to close beds and to get people out of hospitals more quickly. They see this as a form of gaming in which hospitals shift responsibility for caring for high needs clients to the community but little or none of the funds saved by bed closures are transferred to the community.

There is considerable interest in population based capitation models. There are generally two versions of this approach. The first could be called an equity model in which payments are made to an organization with a given number and mix of people (a region, or a rostered Integrated Health System) based on the total population and its age and sex distribution (and possibly other characteristics). This is sometimes referred to as an equity based model as the aim is to provide more equitable funding based on the age and sex distribution of the population. Needs based funding models try to measure the actual need for service by proxies such as morbidity, socio-economic factors and other proxies. Another more expensive variation would be to do actual needs assessments on samples of the population. In general, the equity model of age and sex adjustment is often considered to be appropriate for planning purposes. There is, however, less consensus on needs based models because there is still disagreement about what measures are appropriate. In addition, needs based variables tend to account for a relatively small amount of the variance in health status across geographic areas, after one has adjusted for total population and the age and sex distribution of the population. Typically, the problems related to this approach have had to do with implementation. Funding formulas may provide windfall profits to some regions and a significant drop in resources to other regions. Also, it may be difficult to gain acceptance for a complex funding formula which people do not readily understand. If they do not understand the formula they may question the

relative equity of the funding model. These potential problems can be mitigated by involving agency representatives in the development of the model and by obtaining initial agreement on a set of principles to be used in designing the funding model at the beginning of the process. The funding formula should clearly reflect the principles that are adopted.

While capitation is the model touted as being most appropriate for the new multi-service organizations such as regional health authorities, primary care and integrated health systems, it is also possible to fund these organizations using budget based models. This is what happens, at least implicitly, in funding the sole hospital or long term care facility in a small community. In this case the population based nature of the funding is implicit rather than explicit. Thus, conceptually at least, one could hold a provider, agency, or multi-service organization accountable for providing services for a given geographic catchment area but base reimbursement on models other than capitation, e.g., models based on historical agency expenditure patterns.

There are relatively few examples of funding based on performance. However, there is a growing interest in performance-based contracting so that funders can pay for actual outcomes. Such models may fit best with large complex organizations responsible for given populations. System level outcome measures, or a report card, could be used to assess performance. However, health status is determined by more than just the health system, and it may be difficult to justify such macro-level approaches. Performance contracting can also be used at the individual agency level where certain outcomes are specified in the contractual agreement and payment is based on the extent to which the outcomes are actually met.

## **5.2 Other Key Concepts Related to Funding**

There are some other key concepts which also come into play in any consideration of funding models. One is the nature of the care to be funded. One can develop funding formulas for individual acts of service such as a visit or an hour of care, for episodes of care which may contain several acts of service (such as Diagnosis Related Groups), and for programs of care which may contain multiple types of service and/or episodes of care.

Another important concept is that of prospective or retrospective payment methods. Retrospective payment refers to methods of compensating service providers for the actual expenditures incurred in providing care to an individual or group of individuals. In some circumstances an additional amount (a profit margin or a surplus) may be included in the retrospective payment. Retrospective funding models often use line-by-line budgeting models. Budgets are established based on the previous year's expenditures plus allowances for inflation and other approved costs, and adjustments may be made during the year or at the end of the year to compensate for actual expenditures in the year service was delivered. While in theory retrospective funding models may provide an incentive for greater expenditures by service providers, such expenditures are often mitigated by including ceilings or caps for given line items or aggregates of expenditure within budget allocations. There is little incentive not to provide adequate care, and perhaps some incentive to over-serve with retrospective funding models.

Prospective funding models typically use a set price for the service to be provided. Prospective payments may take the form of a global budget based on the previous year's expenditures plus an inflation factor or payments based on a group average adjusted for case mix and labour costs. These payments may

have no relation to the actual expenditures of the service provider. Prospective payment provides the opportunity for providers to move money within their budgets to provide more cost-effective, and possibly better, care. However, because funding may be disconnected from expenditures, there may also be an incentive to reduce costs to meet funding targets by reducing the amount, or quality, of care provided.

Another key concept is that of case mix adjustment. Case mix adjustment matches expenditures with the care provided, for individuals with different levels of illness or disability. Clients are categorized by functional need (in long term care facilities) or diagnosis (in hospitals). Workload measurement and other forms of research are conducted to determine the average or optimal care required for each grouping within the case mix system. Funding is then linked to the particular mix of clients in a given agency. Case mix adjustment provides for a more direct link between the needs of clients and the funds provided to care for them. In addition, it may reduce resistance from agencies to admit high care needs clients which, from the agency perspective, are also high cost clients.

### **5.3 Funding Continuing Care Services in the Canadian Context**

In Canada we have what is referred to as a social insurance model of care provision for continuing care services. There are a number of common features to how services are delivered and paid for across Canada. While there are also differences, the following discussion will relate to the most common features of the Canadian model.

Financing for continuing care services comes from taxpayers and from the individuals receiving care (through co-payments). Taxpayer funds are allocated to Ministries of Health which partition the dollars into major groupings such as hospitals, mental health, continuing care and so on. In a regional model, Ministries of Health typically have some form of population based funding model that is used to allocate an envelope of funds to the regions. The regions, in turn, break this funding into major budget components, similar to what is done at the Ministry level for jurisdictions that do not have regions.

All jurisdictions have some form of co-payment for residential care. In most jurisdictions some form of room and board equivalent cost is used so that clients typically pay about one-quarter to one-half of the overall cost of care. There are generally no, or low, co-payments for home nursing services and community rehabilitation services (PT/OT). Homemaker services are provided without a co-payment in a few jurisdictions but in most jurisdictions an income test is applied. Clients, depending on their means, may have to pay up to the full cost of care. Most other home and community services also have some form of co-payment. Depending on the jurisdiction, there may be some subsidization of drug costs for seniors. There is a general funding anomaly in home care in that drugs, equipment, and supplies (such as dressings) are provided free of charge in hospitals but may have to be purchased by individuals when they leave the hospital.

In terms of service delivery, most continuing care services are designed for people with ongoing care needs. A relatively small portion of continuing care is focussed on the acute care replacement function of home care, although some people may mistakenly equate home care with just the acute care substitution function.

The typical pattern is for an individual family member, physician, or other person to make a referral to a single entry point for continuing care services. This may be a separate organization such as a

Community Care Access Centre (CCAC) in Ontario, or a health region. Once the referral is made, an assessor/case manager visits the client wherever the client may be, for example, in their own home or in the hospital. A comprehensive assessment is conducted which typically includes a financial section. A care plan is developed with the client and his or her family, with input from the family physician. The client is advised of the care plan and the co-payments he or she may have to pay. The client then receives the service or services designated in the care plan and makes the appropriate co-payments.

Ministries of Health or Regional Health Authorities may fund external service provider agencies or services may be provided directly by staff of the Ministry or Region. With regard to facility care, most jurisdictions use some form of case-mix funding to match payments to the care needs of clients. Home care clients, using their own funds or with the help of family members, may purchase additional services above those paid for by government (at the full cost) if they feel that the care plan does not fully meet their needs. Client needs are reviewed on a regular basis by the case manager and the service plan is adjusted, as needed, to ensure the best fit between client needs and the care provided, on an ongoing basis. Ministries of Health and Regional Health Authorities are responsible for the overall stewardship of the health system. They are responsible for regulating and monitoring the quality of care provided and for ensuring reasonable access to needed services in their respective jurisdictions.

## **6. FINDINGS FROM THE NATIONAL CONSULTATION**

While the conditions for collecting data for this project were close to ideal it turned out that it was not possible to obtain as much of the data as was anticipated. It was recognized from the outset that it would be unlikely for all jurisdictions to be able to provide all of the data given the complex nature of continuing care and the range of services on which data were requested. It was also known that the lack of nationally comparable data was a long standing issue in continuing care. However, there was strong support for the project among respondents. The data requested had some complexity but was not beyond what one could expect to obtain and the research team was diligent in following up and prompting respondents about obtaining the data.

While the interview portion of the consultation went relatively well, the data collection using the tables was only moderately successful. Thus, this project may serve as an early warning flag to the F/P/T ACHS that it may become increasingly difficult to obtain national data, at least on continuing care services. There appear to be several factors which may contribute to this problem. Regionalization and restraint have reduced capacity in Ministries of Health across Canada. Prior to regionalization there were generally specialists in finance, in service delivery and utilization, and in policy for continuing care services at the provincial level. Restraint has meant that there are now fewer people to do the same, or more, work and regionalization has meant that staff have a wider range of responsibilities. They may also have less access to information as the responsibility for service delivery has shifted to the regions and information systems at the provincial and regional levels may still be in flux. It was clear that the officials participating in the consultation were very supportive but the urgency of issues within their Ministries meant that they had limited time to assist in the data collection process. In addition, people who knew financial and data matters may have been re-assigned or given broader mandates. Furthermore, in some jurisdictions funding had been completely delegated to the regional level. This meant that while provincial Ministries had data on financing and funding regions, some no longer had specific data on continuing care service delivery

agencies. Our approach, which was suggested by some of the jurisdictions, was to obtain as much information from provincial Ministries as possible and then go to the regions for the remainder of the data.

In spite of the difficulties noted above, useful information was obtained. Table 6-1, presents a summary overview of which services are considered to be part of the continuing care system in each jurisdiction. Services which are consistently provided across jurisdictions and can be considered to constitute the current “core” services in continuing care are: long term care facilities (including chronic care), palliative care, respite care, assessment and case management, home care nursing, community rehabilitation (PT/OT), and homemaker/personal care services. Other commonly provided continuing care services included: meal programs, adult day support, group homes, equipment and supplies, and quick response teams.

It should be noted that most of the services in Table 6-1 are available in most jurisdictions even if they are not considered to be part of the continuing care system itself. Where they are not directly part of the continuing care system there are generally linkages between these services and continuing care.

## **7. FINDINGS RELATED TO FUNDING CONTINUING CARE SERVICES IN CANADA**

### **7.1 Introduction and Context**

Governments and regional boards are faced with public expectations of providing stewardship for a caring, quality health care system and for ensuring the cost-effective use of public funds. Thus, Ministries of Health have been facing two competing imperatives, to be efficient purchasers of services and to ensure a responsive and high quality health system. They must do both in an environment with significant barriers to market entry (particularly for hospitals and long term care facilities) and a public which does not wish to see health care providers go out of business.

In terms of responding to these competing challenges governments can adopt at least two responses. One is to be a partner with the health care organizations they oversee and to take on joint responsibility, and accountability, with providers about the cost and quality of health services. The other approach is to devolve responsibility to health providers and take on the role of an efficient purchaser of services in a more market oriented model. The characteristics of these two approaches are presented in Table 7-1.

During the 1990s there has been a shift in the role of Ministries of Health in a number of jurisdictions. Until the early 1990s, Ministries of Health typically had more of a partnership approach to dealing with service providers. Given the fiscal restraint of the 1990s that approach started to shift as regional models of care were developed. Regionalization allowed Ministries of Health to shift responsibility for care delivery to the regions. Ministries of Health still maintain an overall responsibility for the stewardship of the health system but are now more focussed on monitoring and measuring effectiveness. Resource allocation to regions is typically on a capitation basis which reduces the latitude for gaming. While regionalization does not directly represent a market model it has some of the same characteristics of more clearly separating the purchaser from the provider of service.

**Table 6-1: Services Included in Continuing Care by Type of Service and Jurisdiction**

TYPE OF SERVICE	Jurisdiction										
	NF	NS	PE	NB	ON	MB	SK	AB	BC	NT	YT
<b>FACILITY CARE</b>											
Long Term Care and Chronic Care <sup>1</sup>	X	X	X	X	X <sup>1</sup>	X	X	X	X <sup>1</sup>	X	X
Assessment & Treatment Centres	X						X	X	X	X	X
Subacute Care							X	X	X		X
<b>PALLIATIVE/RESPITE CARE</b>											
Palliative	X	X	X	X	X	X	X	X	X	X	X
Respite	X	X	X	X	X	X	X	X	X	X	X
<b>HOME/COMMUNITY CARE</b>											
Assessment & Case Management	X	X	X	X	X	X	X	X	X	X	X
Homemaker/ Personal Care	X	X	X	X	X	X	X	X	X	X	X
Home Care Nursing	X	X	X	X	X	X	X	X	X	X	X
Community Rehab (PT/OT)	X	X	X	X	X	X	X	X	X	X	X
Meal Programs	X			X	X	X	X	X	X	X	X
Adult Day Support	X		X	X	X	X	X	X	X	X	X
Group Homes	X			X		X	X	X	X	X	
Equipment & Supplies	X	X		X	X	X	X	X		X	X
Transportation Services	X			X	X	X	X				
Congregate Living/Supportive Housing					X	X	X	X			
Quick Response Team		X			X	X	X		X		
Home Maintenance and Repair	X				X		X			X	
Self-Managed Care	X				X	X		X	X	X	

Note: X = part of continuing care

Note: Findings only presented for jurisdictions which provided data.

<sup>1</sup> In most jurisdictions chronic care beds are now considered to be part of the continuing care system. The exceptions are Ontario and British Columbia but recent steps have moved the chronic care sector closer to continuing care in both jurisdictions.

**Table 7-1: The Partnership and Market Models of Funding Third-Party Providers**

<u>Partnership Model</u>		<u>Market Model</u>	
1.	Ministries of Health focus on working relationships with provider organizations.	1.	Ministries of Health focus on developing criteria for measuring efficiency and effectiveness.
2.	Ministries of Health are flexible and may make compromises in the development, negotiation and administration of contracts.	2.	Ministries focus a high degree of specificity on issues of program design and budget.
3.	Contracting decisions are primarily made on the basis of concerns for the stability of the health industry.	3.	Contracting decisions are primarily made on the basis of cost and price, other factors being equal.
4.	Ministries of Health are cautious about experimenting with different approaches to service delivery.	4.	Ministries encourage experimentation with alternative methods of delivering services.
5.	Ministries of Health promote specialization, rather than competition, among service providers in order to capitalize on their sector strengths.	5.	Ministries focus on developing a pool of service providers who compete for the right to provide services.

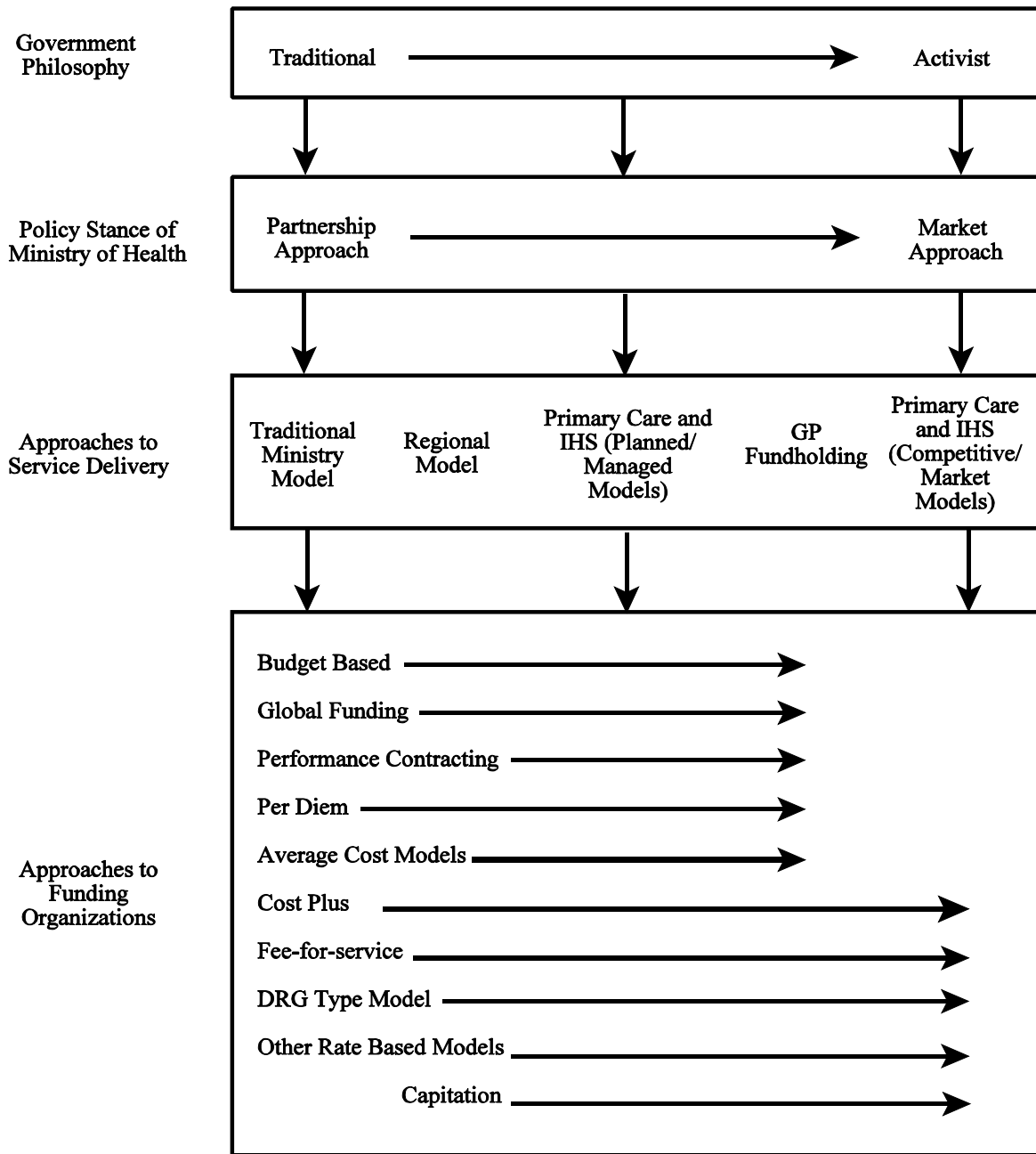
One can apply this concept of the partnership versus market model to models of reimbursement. In order to be effective, models of reimbursement should be congruent with larger issues such as government philosophy, the policy stance of Ministries of Health and the structural approaches to service delivery. The relationship of all of these factors to specific reimbursement models is presented in Figure 7-1. One can see the congruence of the models of health care delivery with the partnership and market models on a continuum from a more traditional model of care to a competitive model of care with competing Integrated Health Systems.

While many writers and commentators note that regional models and other more competitive market models should be funded on a capitation basis, capitation is not the only logical alternative. Capitation models are often difficult to implement in practice. One can use Figure 7-1 as a type of diagnostic tool for looking at funding options. Once a funding approach is under consideration one can take a vertical “slice” of Figure 7-1 to see if the funding approach is congruent with the approach to service delivery, the policy stance of the Ministry of Health or the region and the overall philosophy of the government.

This introduction has been presented in order to underscore the point that the advantages and disadvantages, and the incentives and disincentives, of any funding model must be understood within a broader policy context. Certain characteristics of a given model of reimbursement may be seen as positive in a partnership model of care and negative in a market model while the opposite may hold for another approach. Thus, context is important.

This chapter provides an analysis and discussion of the most common models of reimbursement for continuing care services in Canada today.

Figure 7-1: Congruence of Philosophy, Policy, Service Delivery, and Funding



## **7.2 Analysis and Discussion of Common Reimbursement Models in Continuing Care**

### **7.2.1 Introduction**

It is interesting to note that with regionalization, many previously independent health care agencies have been absorbed into regions. In addition, existing funding models for continuing care, with one exception, are quite traditional. This sets up an interesting dynamic in which Ministries of Health have adopted more of a purchaser and evaluator of service model while some regions appear to have adopted a more traditional partnership model. The extreme form of this model is the provision of services directly by regional staff. Two other models of reimbursement that seem to dominate are a retrospective budget model for facility care and a per hour/visit purchase model for home care. These models are typically associated with a greater sharing of responsibility for health services by the funder and provider.

There is one newer and more innovative model that appears to be emerging in some regions, tendering for home care services. Finally, some jurisdictions use case mix models for funding long term care facilities. Case mix funding can be imbedded in budget based or global models of funding. It can also refer to a form of funding in which specific per diem rates are tied to each level of care for a given service, or, to a model on which a case mix adjusted weight is assigned to a facility and it is funded in relation to a given standard of the “average case mix” facility.

### **7.2.2 The Direct Provision of Service Model**

In this model the region does financing, resource allocation and service delivery. It generally takes two or more parties before one can engage in gaming. Thus, it is likely that whatever gaming exists goes on within the organization itself between managers competing for funding for their areas of responsibility. They may claim special circumstances, point out their comparative needs, discuss relative equity and/or simply work to build good relations with those who decide who gets what funding. In a larger framework, regions may try to obtain more funding from Ministries of Health for their services by challenging the funding formula, asking to have deficits covered, or claiming unique circumstances.

### **7.2.3 The Retrospective Budget Model**

As noted above, this is a model in which a draft budget is prepared based on expenditures in the previous year plus an inflation factor and any agreed upon adjustments. Funds are expended and deficits are covered at the end of the year. Surpluses are either recovered or applied against the budget for the following year. One can maintain greater control over quality in a budget based model but there is a danger of costs increasing at a greater rate than may be the case for other models of reimbursement. It has been noted, however, that by good bargaining and judicious use of pressure it is possible to limit budget increases.

This approach has been used in the Canadian context for a long time and is a common model across the country for long term care facilities. It has survived even in times of restraint where the emphasis has been to shift responsibility for expenditures to service provider agencies. It is likely that this model has survived because it gives government a good handle on expenditures and this is useful for accountability reasons. It also allows government to shift money to meet new challenges without having to change

funding systems or make special payments to agencies. Finally, government has good fiscal levers to ensure the quality of care.

In terms of gaming this typically happens during the period in which budgets are negotiated although strategy may be developed throughout the year. Typical approaches used are to find another agency that is better off in some way and argue for parity or relative equity with the other organization. Agencies may play the quality of care card if there has been some scandal or they feel the funder is vulnerable. This may take the form of arguing for a half time recreation therapist, a new century tub or some other care related item. If the focus is on efficiency, agencies may argue for better computers, newer software packages, or a part-time accountant.

It is regrettable, but it seems to be true that the agencies which “make a lot of noise,” involve their local community leaders and politicians, threaten to go public with some scandal, threaten to close their doors, and use other such tactics are the ones which tend to get at least some additional resources that may not be provided to other agencies. However, those who live by the sword may die by the sword and such agencies may receive nasty surprises when they are vulnerable or when someone in authority wishes to set an example.

An important point to note is that there are significant barriers to entry in the long term care facility sector. It takes time to build a new facility and have it licenced and staffed. Thus, it is in the interests of both the funder and the agency to maintain an ongoing working relationship. Funders are vulnerable if agencies decide to close facilities. These funders also have limited leverage over agencies because closing an agency for non-performance can have several negative consequences including the problems related to relocating clients into other institutions. The issue of barriers to entry and exit seems to be an important one in that the higher the barrier the greater the negative consequences of facility closures. This reality may constrain funders from adopting funding methods that put so much financial pressure on facilities that they might have to close. This is clearly the danger in adopting a DRG model or a strict case-mix model for long term care facilities. There may be facilities that cannot continue to operate and those that may receive windfall profits. Any move to shifting greater fiscal responsibility to agencies should be accompanied by some form of transition stage, or the reimbursement cut-off level adopted (e.g., facilities will only be reimbursed at the average cost for all facilities) should be high enough to allow most agencies to survive.

It is possible to shift some further fiscal responsibility to facilities by adopting global budgets, or by using floors, ceilings and/or averages for parts of the budget over which management of the facility has some control.

#### 7.2.4 Per Hour or Visit Funding

This is the most common model of funding for home care services. The incentive for the provider is to do more, but shorter, visits if funding is provided on a per visit basis. Per hour and per visit funding do not have built in incentives to teach clients to care for themselves. Some agencies may also go over their annual allocations and argue client need in order to be awarded more hours or visits in subsequent years.

Unless there are very tight caps on the amount of service that can be provided this model can provide enough care and there are no major pressures to reduce the quality of care. Thus, both for this model and the budget model, there may be pressure for cost increases but agencies can maintain the

volume and quality of services agreed to with the funder. Once service is purchased primarily on price, issues of labour relations and the quality of service begin to emerge.

#### 7.2.5 Tendering

The move to tendering for home care services in some regions is an interesting development. This is clearly an approach that fits the efficient purchaser in a market model. However, it is confusing. It is contradictory to the more partnership types of models used by regions with other health care agencies. Perhaps this model is used because there are fairly modest barriers to entry and new agencies can come into the market to underbid and replace existing home care agencies. One can tender on price, tender on price and quality, or set a given price and tender on quality. There is a great deal of work involved in the tendering process and considerable disruption to the lives of workers in unsuccessful agencies.

This approach is also confusing because having a number of home care agencies allows for competition in internal markets yet there are examples of regions that use tendering to reduce the number of agencies and set up geographic monopolies with one agency per geographic area. This does not particularly foster competition in internal markets. However, it may be more administratively convenient for the funder to have fewer agencies, and specific agencies to serve specific geographic areas. It is argued that tendering will reduce the number of different home care staff going into an individual's home. However, this problem may be more a consequence of using casual labour to reduce costs than of multiple agencies.

The experience in the literature indicates that tendering will tend to drive out not-for-profit providers. There are also different dynamics if tendering is done for all agencies on a regular (e.g., annual) basis or if one only re-tenders for new services. Regular tendering may allow previously unsuccessful agencies that have reduced costs and/or increased quality to come back into the market. It also allows new low-cost agencies into the market, thus keeping prices low. Tendering can also be done once to achieve some goal such as a reduction in the number of agencies. There are several possible ways to set rates for subsequent years. It is too early to tell which models will predominate in terms of regular versus less frequent tendering and, for the latter, which methods of setting rates in subsequent years will prevail.

#### 7.2.6 Case Mix Funding

Case mix funding provides a closer fit between the care needs of the clients and the funding provided. Without case mix adjustment, facilities have an incentive to admit low care level clients who may not need to be in facilities and this, in turn, may inhibit entry for clients with higher care needs. Typically, for jurisdictions that do adjust for case mix, adjustments are made annually or every six months.

With regard to facilities there are generally three approaches to case mix funding. Case mix adjustments can be imbedded into a budget or global model of funding. One can also fund facilities using an average case mix score for the facility or by having specific per diem rates for each level of care.

In a budget model in which case mix is used, one may have staffing ratios for each level of care. Typically, care staff costs will vary by level of care as more, and more professional, services will be provided to individuals with higher care needs. One adjusts the base budget every six months or annually by calculating the costs for care staff at the base period and six or 12 months later, based on the case mix

at the two points in time. Other costs are held constant. If costs are higher or lower at the 6 or 12 month point the budget is re-calculated to reflect the change in case mix. This approach was used in British Columbia to case mix adjust budget models and global models of funding long term care facilities in the 1980s and early 1990s.

Another approach to case mix funding is the one used by Alberta and by long term care facilities in Ontario in the 1990s. The cost of the “average” facility (using provincial data) is determined and a score of 100 is assigned to the average facility. Clients are assessed once per year and are re-assigned their existing care level or a new care level. The new case mix of the facility is calculated and compared to the “average” facility for that year and the facility is assigned a case mix score. If, for example, the score is 120, the facility will receive 20% more funding than the average facility for the coming year.

The third approach is to calculate a per diem rate for each level of care and to reimburse facilities on a monthly basis based on the number of actual bed days used in the month for each level of care. One can set facility specific per diem rates for each level of care or use regional or national rates with adjustments for variations in labour costs across geographic areas. This is the general approach used to fund facilities in the United States using the RUG III classification system.

Case mix funding generally provides a better fit between funding and the care needs of clients. There are some possibilities for gaming by “charting for dollars” if data are collected from client charts or if facility staff are used to assign care levels. This is why in most jurisdictions government staff or independent agencies are used to manage client care for the overall continuing care system and to assign care levels.

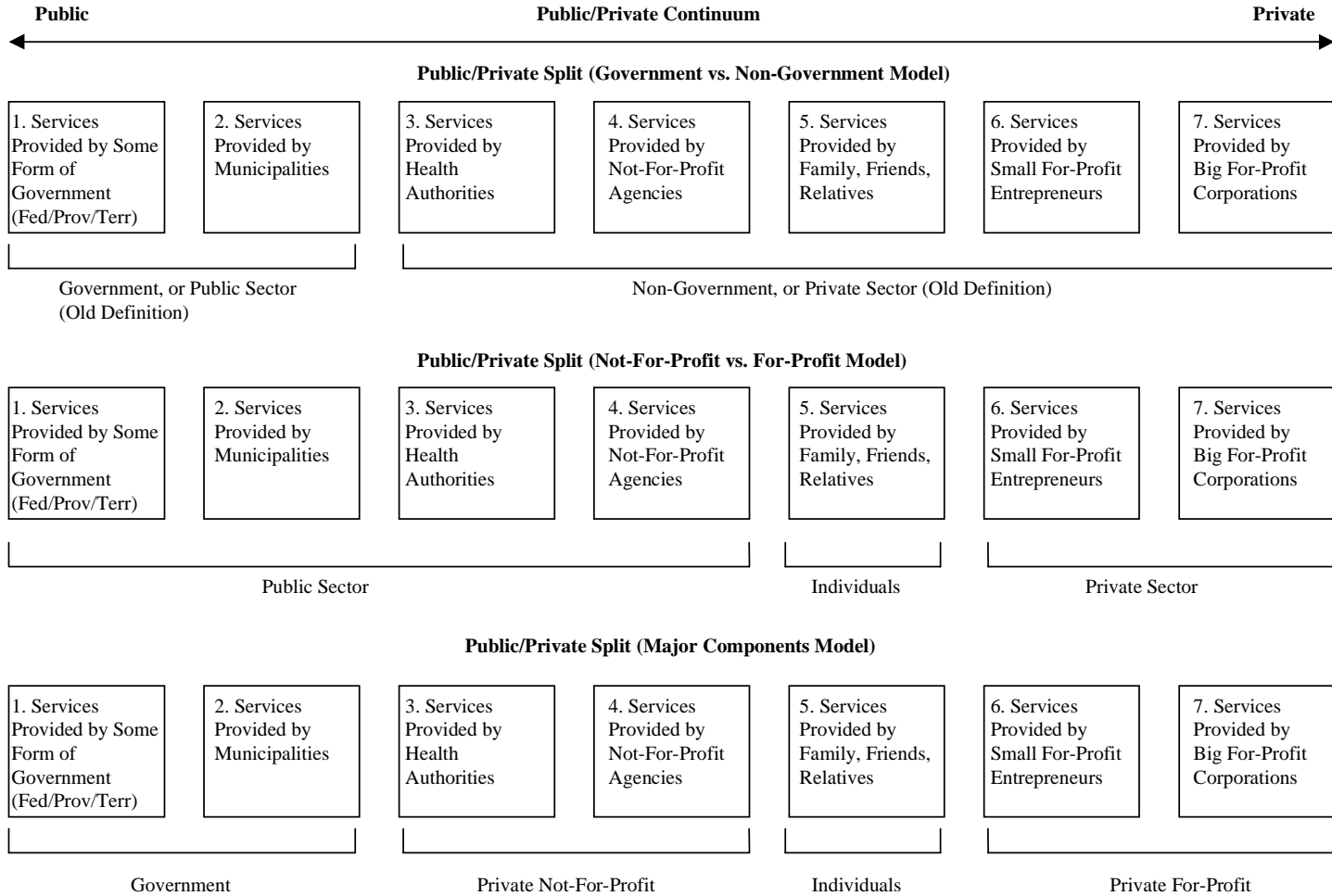
## **8. FINDINGS RELATED TO THE PUBLIC/PRIVATE MIX**

### **8.1 The Public/Private Mix in Service Provision**

Publicly delivered services are generally understood to be services provided by federal, provincial and territorial governments. Some services are also provided by municipal governments. Private services are generally understood to be services provided by not-for-profit organizations, or by for-profit organizations such as small businesses (e.g., a family-owned long term care facility, fee-for-service physicians) or corporations. Private services can also be provided on a paid or unpaid basis by family members, friends, or relatives (that is, by individuals with some kind of link to the care recipient). The discussion in this section is based in large part on case study one on the public/private mix.

As can be seen from Figure 8-1, the continuum of public to private services can be split several different ways. In the older or more traditional definitions, public services are services provided by the first two types of entities, that is, federal, provincial, territorial and municipal governments, and everything else is private. This is essentially a split between governmental and non-governmental service provision. Another method of defining the public/private mix in service delivery is to aggregate the broad public sector into one group, for-profit organizations into another group, and individuals into a third group (the not-for-profit versus for-profit model). This is essentially a public sector versus private sector split. The public/private mix can also be broken into major components: government, not-for-profit organizations, individuals, and for-profit organizations (the major components model).

**Figure 8-1: The Public/Private Continuum for Service Providers**



In terms of service provision, services in Canada are often provided by separate or third-party, for profit or not-for-profit, agencies (a private approach to care delivery). The case management function, and in some jurisdictions actual service delivery, is provided by government employees (a public approach to care determination and delivery).

## **8.2 The Philosophical Basis of Care: A Question of Equity**

Findings from this report, and other studies, have revealed that for home care many jurisdictions have no user fees for professional services but have user fees, based on an income/asset test, for homemaker and care aid services. This reflects both historical and philosophical traditions. Historically, home care nurses and rehabilitation specialists were seen to be part of the “health” system. Many such persons work in hospitals which are insured services. Thus, such services have generally been provided without a fee. Homemakers, care aids and many other services included in continuing care come from social services where there were generally income tests. Philosophically, Canadians generally want to have health services provided on a “universal” basis, that is, fully accessible services available to all on equal terms and conditions without co-payments. Social services have come under the residual welfare model in which the state only pays for services which individuals cannot pay for themselves. Thus, while continuing care is now in the universal “health” system much of it is still funded on a residual welfare model. This causes constant tension. There is currently pressure to focus on more professional, acute care replacement home care, under the medical model. However, the history and tradition of much of home care and residential care has been that of a social support or socio-medical model. The case studies make clear that while professional services are certainly helpful, what allows most home care clients to stay at home is the range of social supports provided. Thus, current practice raises the policy issue of the relative equity of clients having to pay for one type of needed services but not another. In addition, there may also be inequities between individuals who mostly need social support and those requiring primarily medical interventions. Both types of clients are included in continuing care but the costs of care to these two types of clients may vary significantly if professional services have no co-payments while more supportive services have co-payments.

A related issue for facility care is the anomaly that in Atlantic Canada people who are admitted to long term care facilities are income/asset tested and if they have sufficient funds may have to pay up to the full cost of care. Thus, they pay the room and board, and care, portions of the cost. In the rest of Canada facility clients pay a user fee generally between \$20 and \$50 per day. Clients may still be income tested but they are only required to pay what amounts to the room and board portion of care (costs they would have to pay if they lived at home) and the state pays for the care portion of costs. This anomaly is something that decision makers may wish to address.

Case study one reflected the tension noted above. There has always been a public/private mix in continuing care. However, the question is whether the trend is to greater private payment, and/or private delivery, as noted for Alberta and Nova Scotia in the case study, or whether this trend will be reversed, perhaps through the infusion of additional funding from the federal government.

### **8.3 Private Payment**

There is currently little available information on the private or out-of-pocket payments clients make for their care. There is a complex gradation of “private” payments which includes:

- Private payments made by individuals to totally private agencies (e.g., care facilities) which receive no funding from government
- Private payment for the full cost of care in an agency which has some government subsidized clients
- Private payment for “top up” or additional services over and above those approved by government
- Co-payments for services approved by government to a service provider who has other subsidized clients.

Given the importance of housing outlined in case study two on the hospital to home care interface, it should be noted that assisted living housing seems to be a major growth market for the private sector and one that may have policy impacts as individuals age in place (remain in one location or type of service setting as their care needs increase with age) and come to have increasing care requirements.

### **8.4 Private Insurance**

If the decision is made to shift more costs to individuals then there may come to be an increasing market for private insurance. The experience in Nova Scotia indicates that this could become a complex problem as one mixes private insurance with a publicly funded system. Who is the payer of last resort, and will insurance companies honour claims? Policy makers will need to consider if they wish to bolster the existing public system or move to a more insurance based model. If the latter is chosen, the public should be made aware that they are on their own and will need to take appropriate steps to protect themselves through the purchase of insurance. It should be noted, however, that there is an extensive literature on private insurance approaches in the United States that seems to indicate that no truly effective mechanisms for private insurance have emerged to date.

### **8.5 Cost-Effectiveness**

With regard to the issue of a publicly funded versus an insurance based continuing care system, offloading costs to consumers may reduce public health care expenditures. However, the single payer Canadian system has several advantages over an insurance based system including lower administrative costs. Moving to a more private pay insurance based model may reduce costs to government but not to society as a whole.

Another recent trend has been to increase user fees for facility care. In the 1980s there were often no income tests and all clients paid the same fee which was set at a rate that could be afforded by those who only received Old Age Security and the Guaranteed Income Supplement (OAS/GIS). If this trend to increase facility care user fees continues it may become less cost-effective for government to care for people at home. For example, if a facility per diem is \$100, of which the user fee is \$20 and government pays \$80, and if \$50 per day is spent by government on home care for an identical client, home care is a cost-effective alternative to government. If the user fee is \$60 and government pays \$40 per day for facility

care, the cost of home care will be greater than cost of facility care from a government perspective. This could result in pressure to increase the number of facility beds.

A lack of case mix adjusted funding may encourage facilities to admit lower level care clients which, in turn, may block beds for higher level care clients who need them. Having a system in which people pay up to the full cost of care also facilitates private pay clients jumping to the head of the line and not having to go through an assessment process. Finally, co-payments in the community for drugs and dressings which are available at no cost in hospitals may impede the smooth transfer of clients to home care and may disrupt the cost-effective substitution of home care for hospital care.

## **9. FINDINGS RELATED TO THE HOSPITAL AND HOME CARE INTERFACE**

### **9.1 Shifting Patterns of Home Care**

As was noted in case study two on the hospital and home care interface there is increasing pressure to expand the availability of home care services. Making home care available seven days per week and 24 hours per day will take many adjustments and conscious policy choices. The pressure for such action is growing as the proportion of clients receiving short term, post-acute home care increases due to pressures for greater efficiency in hospitals. Another trend that will need to be addressed by senior managers is the tendency for clients to go to their politicians and lawyers to pressure home care staff or case managers to provide more care. This is a complex matter and may need serious attention if it becomes a trend rather than a series of isolated incidents.

### **9.2 Home Care as a Substitute for Acute Care**

The international literature is mixed and there are relatively few Canadian studies on the cost-effectiveness of home care as a substitute for acute care. While the findings in case study two on the hospital to home care interface are clearly tentative they do seem to lend some support to the contention that home care can be an effective alternative to acute care services. It appears that there were clear reductions in Alternate Level of Care (ALC) days in hospital as a consequence of enhanced home care services in two case study locations. Further study is clearly required, however, before any firm conclusions can be reached. Another area worthy of study is whether the hospital to home care interface works better for community hospitals than for larger tertiary hospitals.

### **9.3 Key Elements for a Successful Hospital to Home Care Program**

An analysis of the findings in case study two reveals what may be key elements for a successful hospital to home care program. These are:

- The Board and senior management have to exhibit vision, leadership and commitment to the initiative. This is probably a critical success factor.
- There must be some degree of separation in how funds are shifted between hospitals and home care. If the transfer is too direct and people lose jobs as part of the transfer there may be ill will that can linger for a long time.

- Transitional beds may be a useful component of a hospital to home care initiative because they allow people to recover to the point where they can go home instead of to a long term care facility.
- Developing initiatives on a direct cost recovery basis may cause some problems. It is also a questionable option in that other sectors of the health system, such as hospitals, generally do not have to justify new investments.
- Services are connected in an overall system of health care. Thus, one should consider whether proposed changes to acute care services may have a negative effect on continuing care services before such changes are implemented.
- Effective discharge planning is a key to the effective transfer of clients from the hospital to continuing care services.
- Finally, it is a good idea to involve physicians actively and from the beginning of the initiative. They have a great deal of influence about how and when clients can move from the hospital back to their homes. There may also be some benefit to a greater involvement of physicians in home care.

## **10. FINDINGS RELATED TO DECISION MAKING UNDER CONSTRAINT**

The case studies conducted for this project, and the interviews with senior continuing care industry representatives, found that continuing care is under stress and strain. While money is not the only solution, some new money may well be required to deal with increasing pressures, particularly on home care. Stress leads to issues such as labour relations problems, turf protection (refusal to transfer functions to other professions), rigid policies that serve to exclude clients who may benefit from care and staff burnout. Case study three presents a picture of how agencies and front line workers function in a system under stress. The case study looked at how managers and front line staff cope in a context in which there is a fixed budget but continual pressure to provide services on demand.

An important finding of case study three is the extent to which external factors affect allocation choices at the front lines. Analysis of case study three revealed that decisions are directly influenced by macro-contextual factors including both fiscal and demographic imperatives. The system is being pressured by reduced hospital stays, clients with a higher level of acuity, capped budgets and issues surrounding the recruitment and retention of staff. Coupled with these macroeconomic issues are other indirect influencing factors including the historical underpinnings of the home care program, organizational values, variations in the educational backgrounds of case managers, length of service of case managers, and the desires of the client and his or her family. These direct and indirect factors influence management and staff to respond or "cope" by:

- Prioritizing
- Working outside convention
- Building community
- Finding innovative ways to meet the need (negotiating and gaming)

An important finding of this project is that formal care givers may go out of their way, or "bend the rules," to get clients the help they need in a stressed system. Hospitals find ways of supporting clients in need who may face financial hardship by providing drugs, dressings and other items free of charge even

after the client leaves the hospital. Case managers mobilize resources outside the continuing care system to get clients the help they need. Thus, front line agencies and care staff have taken direct action to counter problems related to important policy issues which have yet to be resolved.

Faced with scarcity, staff have been creative in responding to the needs of clients. They work to obtain what is needed for their clients from the community and other resources. This action may include more conventional activities such as starting new programs, for example, a wheels to meals program. It can also include doing “creative” assessments to ensure clients are eligible for needed services. This is a response to policies that segment the resources available to clients. For example, case managers may authorize some professional care for a client in order to be able to provide the homemaker services the client needs in a system where clients can only get homemaker services if they receive professional services. Finally, it also includes getting community resources, and redistributing resources, to help those in need. The example of the rural case manager who was able to barter chickens for a raised toilet for one of her clients is particularly poignant. While the result was positive, needed, and perhaps heroic, one must ask if decision makers really want a system that pushes trained professional staff to such extremes.

Finally, case study three noted that case managers work to get the assistance their clients need by building a supportive community around them. Without in any way negating the medical needs of clients, this again clearly points out the importance of the social aspects of care and support to clients living in the community.

## **11. LESSONS LEARNED AND KEY POLICY ISSUES FOR CONSIDERATION**

### **11.1 Lessons Learned**

A great deal of work was done for this project and one could make a long list of conclusions. However, what appeared most striking was the lesson that it is people who make things happen. If staff and managers are motivated and put the client first, they can develop coordinating mechanisms to facilitate care in almost any type of system. There is no substitute for vision and leadership from Boards and senior management. What is needed is a mutually supportive organizational vision that links the front line details with the larger policy framework, and mechanisms by which all layers of the organization can work to support each other and the clients they serve.

In the work done for this project a number of specific lessons were learned about what senior management and decision makers can do to improve care. These are:

- Focus on the unmet needs of clients and give them a very high priority. That is, build an organizational culture and system of policies and procedures that puts the client first.
- Be more open to innovation and experimentation. To date we have worked to ensure that everyone is treated equally. By focussing on client needs and recognizing that different people may need different responses, rather than on ensuring that everyone is treated the same, we may be able to improve client care and systems effectiveness.

- Balance clinical and financial aspects. Allow case managers to be advocates, within an existing fiscal framework, and let senior management find ways to deal with fiscal realities. The care of clients and the efficiency of the care system may well suffer if case managers are asked to become primarily fiscal policeman.
- Be clear about values. As noted in this report, the perspective on whether a given approach to funding is “good or bad” is related to the larger context and the overall values which shape policy and service delivery. There is less probability for confusion, in regard to selecting appropriate funding models, if there is clarity about whether one is more managerial or activist, more a partner in care or a purchaser of service, and whether one focusses more on public or private models of payment and delivery.

## 11.2 Proposed Guidelines for Selecting Funding Models

When one is considering how to fund continuing care services it may be useful to keep in mind the following general guidelines:

- **Funding mechanisms should be congruent with fiscal and program goals.**

An example of a funding model which may not be congruent with goals related to cost, quality, and access is that of long term care facilities, without case-mix adjustments. Evidence from the literature indicates that using a blended per diem rate may provide an incentive for facilities to admit low care needs clients and not admit high care needs clients. In addition, by admitting lower care needs clients beds may not be available for higher care needs clients thereby depriving them of needed care or pushing them into hospital beds. Decision makers may wish to review whether or not blended per diem rates have been set at a higher than necessary level to ensure that facilities in Canada will admit higher care needs clients and have the resources to care for them appropriately. It may also be useful to review the extent to which lower care level needs clients actually “crowd out” those with higher care needs in Canada.

- **Funding mechanisms should be structured in a way that provides a balance between price and quality**

As noted previously, jurisdictions may wish to adopt a partnership or a market approach to dealing with continuing care service providers. Budget based models and per hour or per visit models are generally associated with enough resources to provide a reasonable level of care. However, quality assurance or accreditation programs should still be implemented to ensure that the resources available are used to provide the best possible care. The downsides of these funding models are that costs may escalate at a rate greater than for other funding models. In order to ensure that cost increases are kept to an appropriate level one may wish to build floors and ceilings, and even averages, into different parts of an agency’s budget. For example, one may provide a minimum level of funding (a floor) for care staff and food to ensure quality. One may wish to put a cap on potential salary or staff increases to reduce the rate of cost increases and one may wish to

fund the “average” amount for supplies and other administrative costs because administrators can have a considerable degree of control over such costs.

If one is using tendering or case mix funding where there is a separate per diem rate for each level of care one can more easily hold back the rate of cost increases over time. However, these approaches focus primarily on fiscal control. In order to provide some balance, one may wish to build in financial incentives for the provision of good care or at least require, through contracts or regulations, that agencies meet certain quality standards, and make the meeting of such standards a condition of funding.

- **Funding mechanisms should be consistent with the larger policy goals and directions of Ministries of Health and Regional Health Authorities**

It is believed that funding models which are consistent with government policy goals and directions, and are congruent with service delivery models, will be more successful than those which are not. For example, it is unlikely that a capitation model of funding will work well in a context in which government philosophy is to be more managerial rather than to embark on bold new projects, where the Ministry of Health wants to be a partner with service delivery agencies and an active steward of the health care system, and where health services are organized on more traditional lines. There is a lack of congruence between the funding model and the context because capitation funding is a means of shifting responsibility for health services from government to service providers. This approach to funding will also entail considerable disruption because it is not easy to implement. Thus, in this example, the capitation funding model would be inconsistent with the philosophy and policy goals of government and the Ministry of Health.

Similarly if government is activist and Ministries of Health wish to move to a more market based model in which they are a purchaser of service and have shifted responsibility for the delivery of health services to regions or integrated health systems, a budget based model may not be the optimal choice because it does not provide the necessary degree of separation between the purchaser and provider functions.

- **Funding mechanisms between different sectors of the health system should complement each other and provide incentives, rather than disincentives, for greater service integration**

Continuing care services operate within the larger health system. Care should be taken to ensure that there are appropriate funding incentives across service delivery components within continuing care and between continuing care services and other components of the health system. One of the issues noted by respondents in the case studies was the segmentation of policy across components of continuing care and how this provided a disincentive to meeting the care needs of clients. For example, in some jurisdictions home care clients may only obtain home support services such as cooking and cleaning if they are eligible for some form of personal or professional care services. However, some frail elderly people may clearly need assistance but do not have a specific

condition requiring hands on personal care. In this example, the fiscal incentives may be in conflict with considerations regarding the quality of care.

Another example within continuing care is that there are generally no fiscal incentives to promote good care in residential facilities. In a case mix system facilities generally get less funding if they are successful in reducing the care needs of clients. In non-case mix funding models funding may not be reduced but, as noted above, there may be other issues to be dealt with. Decision makers may wish to institute, at least on a pilot basis, financial incentives for moving clients to a lower level of care. For example, facilities could be allowed to keep all or some of the difference in funding as a client moves from one level of care to a lower level of care. Another approach may be to provide specific targets for the proportion of clients per year who reduce their care level. Financial rewards could be provided to agencies which meet these target levels.

A related issue is that of providing incentives for being able to return clients from the facility to their homes. If facilities become more successful at reducing care needs, and levels of care, it may be possible that some clients could go back to their homes or to a supported housing arrangement. Specific financial incentives could be introduced to facilitate this type of transfer back into the community.

With regard to the congruence of funding incentives between continuing care services and other components of the health care system, one should be careful to consider system impacts for any major change in funding or fiscal policy. For example, as hospitals come under fiscal constraint, and as funding moves more toward a DRG model in which case mix groups or resource intensity weights are used in hospital funding models there is a clear incentive for hospitals to reduce their lengths of stay. However, unless some of the potential savings from bed closures or from reduced construction of future beds is moved to continuing care, and particularly home care, this sector comes to feel the strain from hospital discharges. Currently, there appears to be an incentive for hospitals to discharge people faster but no incentive for home care agencies to take on such clients. The home care sector faces increased demand and complexity due to more hospital discharges of increasingly higher needs clients but, in one way or another, home care operates with fixed budgets which provide no incentives for taking on new clients. Decision makers may wish to consider putting in place incentives to take on such clients. This could be done by funding targeted to clients with higher care needs and by enhancing the total dollars available to deal with increased demand. Finally, current policy regarding payment for drugs, supplies, and dressings is a classic example of a financial disincentive between two components (hospitals and home care) in the health care system.

### **11.3 Key Policy Issues for Consideration**

There are numerous implications for policy from the findings of this project. However, it is not possible to deal with everything at once. Thus, the following presents four key policy issues that policy makers may wish to address.

- **Information Systems:** As noted in this report there appears to be room for improvement in the nature, scope and timeliness of information systems in continuing care. Such improvements are essential if we wish to move to evidence based decision making in this sector. There are clearly data gaps in the existing system and there is no national reporting system for home care. Given that continuing care systems differ across jurisdictions we have the opportunity to learn from each other by conducting a series of natural experiments, which would allow us to compare and contrast different approaches to determine their relative efficiency and effectiveness, if similar data were to be collected across jurisdictions. Many of the tools needed for such data collection have recently been developed. It is now a policy choice whether we adopt similar data collection instruments across Canada, or not.
- **Current Inequities:** As noted above, some existing policies lead to inequities. For example, drugs and other items are provided without co-payments for individuals in hospitals but co-payments may be required once a client leaves the hospital. There is also an inequity in facility care in that in Atlantic Canada those with sufficient resources may have to pay for the full cost of care while clients in the rest of Canada may only pay for the “room and board” portion of care in a facility. Finally, there are also differences in the degree to which continuing care services are portable across jurisdictions. Decision makers may wish to consider these inequities.
- **User Fees in Home Care:** Policy makers may wish to consider the differences noted in this report regarding user fees for professional home care services and home support services. Both types of care are needed by clients to allow them to remain at home and, potentially, to prevent institutionalization. Is it still necessary to maintain this difference or can steps be taken to make home support services universal services provided without user fees?
- **Strain on the System:** While it is recognized that money is not the only solution, and that steps should be taken to increase efficiencies, the continuing care system seems to be under strain. This would seem to indicate that it may be time to consider what would constitute an appropriate funding level for this sector.

This project has attempted to provide some insight into the incentives and disincentives and cost-effectiveness of funding models in continuing care. Some interesting findings and policy issues have emerged. We hope that this document will serve as a useful and relevant input to policy making and to improving the lives of those who receive continuing care services.