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

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

Technical Report 4: Case Study on Resource Allocation in Home Care – Saskatchewan and Nova Scotia

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Prepared by:

Karen Parent
Malcolm Anderson
Jim Lavery
Christian Keresztes

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Hollander Analytical Services

QHP Queen's Health Policy

ACKNOWLEDGMENTS

The researchers for this *Case Study on Resource Allocation in Home Care* wish to express their sincere appreciation for those that contributed to the study. We would like to thank the many people who were interviewed for this case study. Their time and insight were much appreciated. We would also like to thank the co-investigators of the overall Incentives/Disincentives Project and the Advisory Sub-Committee of the Federal/Provincial/Territorial Advisory Committee on Health Services Working Group on Continuing Care for their comments on an earlier draft of this report.

EXECUTIVE SUMMARY

The purpose of this case study was to examine resource allocation decision-making processes at various levels in home care organizations (i.e., organizations with the responsibility to coordinate and/or deliver home care). The case study was conducted in two jurisdictions: Nova Scotia and Saskatchewan. Within each of these provinces interviews were focussed on home care organizations in both a rural and urban setting. This is one of three case studies being conducted as part of the Health Canada study of incentives and disincentives in continuing care in Canada, which also includes a national survey of the continuing care sector. The overall purpose of the Incentives/ Disincentives project was to provide more evidence-based discussion of key issues surrounding various approaches to the funding of continuing care in Canada. The material provided by the entire study will be used to inform our understanding of client care and health benefit objectives, assist providers and clients with further knowledge on the sites of continuing care, and enhance our awareness of the issues surrounding the public/private system of funding continuing care services.

Organizations coordinating or delivering home care are functioning in a period of new fiscal realities, changing client profiles and increasing demand for programs and services. There is little understanding, however, of *how* resources are being allocated within these home care organizations. With fixed funding envelopes and an uncertain funding environment, they are using a variety of approaches to allocate resources to meet the growing demand. Decisions are being made on a daily basis by all levels of staff that affect the way resources are consumed.

The success or failure in meeting the needs of clients is predicated on effective decision-making throughout many levels within home care organizations (i.e., from case managers through to the CEO's and Governing Boards). Understanding the dynamics of such decision-making is a vital first step in developing appropriate instruments for allocating fiscal and/or human resources.

Lack of uniformity in approaches to resource allocation in home care across Canada has led to substantial variations in how and which services are provided. These variations occur both between and within provinces, with differences being most apparent between rural and urban locations and for certain sub-populations. Given that most decision-makers in home care organizations are operating under considerable fiscal constraint, this case study is timely in its examination of the nature of decision-making processes and the subsequent effects on service provision.

This study used a qualitative case study approach to develop an understanding of the factors that lead to variations or similarities in decisions around resource allocation in home care. The case studies are based on a series of semi-structured face-to-face and telephone interviews conducted with stakeholders working in the home care sector in Nova Scotia and Saskatchewan. Overall, 82 stakeholders were interviewed in both provinces (38 in Nova Scotia and 44 in Saskatchewan). Face-to-face interviews were conducted in Saskatoon and the Twin Rivers Health District in Saskatchewan, and the Central and Northern Regions in Nova Scotia. Interviews were conducted with home care staff at the case management , administrative levels, and government policy-makers.

Sixty-nine stakeholders were interviewed face-to-face in November and December of 1999 (36 in Nova Scotia and 33 in Saskatchewan). There were 13 additional telephone interviews conducted following the site visits to further validate the earlier round of interviews (2 in Nova Scotia and 11 in Saskatchewan).

Key Findings: Saskatchewan

- Growth in public funding for home care has not kept pace with demand for services, which limits the availability and provision of services.

- The lack of resources requires case managers to function as gatekeepers for the system, a role that can conflict with their roles as service providers and client advocates. These conflicts can create binds that case managers must then resolve.

- Administrators recognize that case managers can not find all the tools and resources they need within the public system and must often seek solutions outside the system envelope, beyond publicly-funded services to private services, and to informal caregivers, family members, neighbours and the community at large. Innovation and creativity are required to identify and mobilize these resources.

- Case managers focus more on "building community" around the client through extensive networking and communication than they do on allocating services among competing clients.

Key Findings: Nova Scotia

- Resource allocation decisions are greatly influenced by the lack of a defined "basket of goods" that should be funded under the public home care system. The lack of clarity has contributed to the growing distinction between, and boundaries established for, the provision of acute and chronic care services.

- The historical roots of the program and public perceptions of entitlement are major factors influencing resource allocation decisions.

- For home care staff, the decision-making process reflects an inherent tension between the fiscal realities and the ability to respond to client needs.

- An integral part of decision-making is the "process of negotiation" with clients, families and other providers. Negotiation, however, is often hampered by the lack of system features such as information technology, evidence-based policy frameworks and provincial standards.

The findings may be summarized by looking more precisely at the meaning of resource allocation in the community context. "Resources" in this context can be interpreted as referring

primarily to human resources, particularly those with the requisite basic physical and intellectual capabilities to provide care for others (increasingly difficult, for example, for elderly neighbours or family). However, “resources” also refer to products and commodities required to deliver care effectively in the home; for example, the lack of availability of machines for home oxygen (even if sufficiently skilled support staff are available) will limit the ability to provide this service to a client with the requisite need. Finally, “resources” also refer to broader aspects of the available community infrastructure, such as spaces for day programs for elderly clients with dementia. The traditional concept of resource allocation, which has an emphasis on discrete, indivisible products/ services/ and incentives does not appear to fit the home care resource allocation pattern, which is less discrete and more divisible than the clinical paradigm infers. Therefore, the terms “resource” and “allocation” both have quite different meanings from use in the clinical context and must be further examined in the home care setting to develop their own typologies of evidence.

Without a clear vision, or a comprehensive account of the goals of home care (e.g., to ensure equality of opportunity), it will be extremely difficult to define what should be part of the publicly-funded home care system in Canada. The end result is uncertainty regarding which services will be accessible, and continued frustration for clients and front-line workers.

Clearly, the goals of home care need to be both philosophically and practically sound to meet the diverse needs of clients who require acute and long-term care substitution, as well as the maintenance and prevention aspects of the program. The debate on what should be an insured service requires an open and transparent public process to ensure that resource allocation decisions in the future are guided by a framework and foundation of participation by all stakeholders affected by the decisions.

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1.0 INTRODUCTION

In 1999, in response to the Federal, Provincial, and Territorial Health Ministers' interest in "supporting high quality integrated acute, continuing and community-based health services" in Canada, the *Identification and Analysis of Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care* project was launched. In addition to a national survey three case studies were conducted in various jurisdictions across Canada as part of the overall project; private/public mix in continuing care, hospital/ home care interface, and resource allocation decision-making in home care.

The purpose of this case study was to examine resource allocation decision-making processes at various levels in home care organizations (i.e., organizations with the responsibility to coordinate and/or deliver home care). The case study was conducted in two jurisdictions; Nova Scotia and Saskatchewan. Within each of these provinces interviews were focussed on home care organizations in both a rural and urban setting. In addition, utilization statistics from the national survey on the continuing care sector was incorporated to provide the contextual backdrop for the reader.

Organizations coordinating or delivering home care are functioning in a period of new fiscal realities, changing client profiles and increasing demand for programs and services. There is little understanding, however, of *how* resources are being allocated within these home care organizations. With fixed funding envelopes and an uncertain funding environment, they are using a variety of approaches to allocate resources to meet the growing demand. Decisions are being made on a daily basis by all levels of staff that affect the way resources are consumed.

The success or failure in meeting the needs of clients is predicated on effective decision-making throughout many levels within home care organizations (i.e., from case managers through to the CEO's and Governing Boards). Understanding the dynamics of such decision-making is a vital first step in developing appropriate instruments for allocating fiscal and/or human resources.

Lack of uniformity in approaches to resource allocation in home care across Canada has led to substantial variations in how and which services are provided. These variations occur both between and within provinces, with differences being most apparent between rural and urban locations and for certain sub-populations. Given that most decision-makers in home care organizations are operating under considerable fiscal constraint, this case study is timely in its examination of the nature of decision-making processes and the subsequent effects on service provision.

Overview of Key Terms

Home care has three key functions (Health and Welfare Canada, 1990):

- *Acute care substitution*, where home care meets the needs of people who would otherwise have to remain in, or enter, acute care facilities.
- *Long term care substitutions*, where home care meets the needs of people who would otherwise require institutionalization.

• *Maintenance and prevention* whereby people with health and/or functional deficits in the home setting, both maintaining their ability to live independently, and in many cases preventing health and functional breakdowns, and eventually institutionalization.

Hollander and Walker (1998, pp. 63-70) identify the following characteristics of home care programs:

> Home care nursing provides comprehensive nursing care to people in their homes, generally by registered or psychiatric nurses. A home care nursing program coordinates a continuum of nursing services designed to support clients of all ages to remain in their homes during an acute, chronic, or terminal illness. This community-based program provides nursing care in the client's own environment. Home care nursing encourages clients and their families to be responsible for, and to actively participate in, their own care. Thus, teaching and self-care are promoted. Goals for home care nursing can be curative, rehabilitative, palliative, or supportive.
>
> Homemaker (home support) services are provided to clients who require non-professional (lay) personal assistance with care needs or with essential housekeeping tasks. Personal care needs may include help with dressing, bathing, grooming, and transferring, whereas housekeeping tasks might include activities such as cleaning, laundry, meal preparation, and other household tasks. Homemakers may have post-secondary training to the same level as Aides, and Care Attendants and may provide similar types of personal care services. Specific nursing and rehabilitation tasks may also be delegated to Homemakers. Homemaking can also be provided as a respite service.

2.0 METHODOLOGY

This study used a qualitative case study approach to develop an understanding of the factors that lead to variations or similarities in decisions around resource allocation in home care. The case studies are based on a series of semi-structured face-to-face and telephone interviews conducted with stakeholders working in the home care sector in Nova Scotia and Saskatchewan. Overall, 82 stakeholders were interviewed in both provinces (38 in Nova Scotia and 44 in Saskatchewan). Face-to-face interviews were conducted in Saskatoon and the Twin Rivers Health District in Saskatchewan, and the Central and Northern Regions in Nova Scotia. Interviews were conducted with home care staff at the case management , administrative levels, and government policy-makers. Sixty-nine stakeholders were interviewed face-to-face in November and December of 1999 (36 in Nova Scotia and 33 in Saskatchewan). There were 13 additional telephone interviews conducted following the site visits to further validate the earlier round of interviews (2 in Nova Scotia and 11 in Saskatchewan).

The data used in the study were the investigators' hand-written transcripts of the face-to-face and telephone interviews described above. The analysis of these data involved 3 main steps: (I) open coding, the process of breaking down, examining, comparing, conceptualizing, and categorizing

data; (ii) axial coding, the process of re-assembling data into groupings or categories based on relationships discovered in the data; and (iii) selective coding, the process of identifying and developing the central phenomena as indicated by the data. Each "step" involves constant comparisons of new data with existing data (Glaser, 1992; Strauss and Corbing, 1990). These processes gave rise to a set of explanatory statements. The qualitative data were then clustered into themes that provide the basis for discussion. Interviews were conducted by one researcher and focussed discussions around three broad questions:

1.)What are the types of resource allocation decisions being made in the home care organization? (What are the choices being made?)
2.) Why are these particular decisions being made?
3.) How are these decisions made?

3.0 DECISION-MAKING IN HOME CARE: SASKATCHEWAN

3.1 Context

Home care was introduced in Saskatchewan in 1978. The program is the responsibility of the Community Care Branch of Saskatchewan Health, which provides provincial policies and procedures, standards and guidelines for the delivery of services, and funding using a population needs-based formula. Home care services are delivered by 32 District Health Boards (DHBs), using a single-entry system and a standard tool to assess the need for home care intervention on the basis of functional need and informal supports. Services include assessment and care coordination, case management, home support and personal care (only in conjunction with other services), nursing, rehabilitation, volunteer services, and, in some districts, social work and respiratory therapy. The majority of services are provided by DHB employees, with some contracting in urban areas only. All residents are eligible for services, with income testing and fees for home support services, including personal care, respite, home maintenance, and meals (Health Canada, 1999).

As a percentage of public health expenditures, spending on home care in Saskatchewan is slightly below the national average, with a rate of utilization that is higher than the national average. In terms of the distribution of clients, the percentage of acute-care clients is lower than the national average, while the percentage of long-term care clients is higher (Health Canada, 1999).

3.2 Summary of Key Findings

- Growth in public funding for home care has not kept pace with demand for services, which limits the availability and provision of services.

- The lack of resources requires case managers to function as gatekeepers for the system, a role that can conflict with their roles as service providers and client advocates. These conflicts can create binds that case managers must then resolve.

- Administrators recognize that case managers can not find all the tools and resources they need within the public system and must often seek solutions outside the system envelope, beyond publicly-funded services to private services, and to informal caregivers, family members, neighbours and the community at large. Innovation and creativity are required to identify and mobilize these resources.

- Case managers focus more on "building community" around the client through extensive networking and communication, than they do on allocating services among competing clients.

4.0 FINDINGS – SASKATCHEWAN

This section has been organized according to four main findings. The first finding highlights the influence of broad contextual features of home care funding and service delivery that are familiar across Canada (Anderson & Parent, 1999) on resource allocation in Saskatchewan. Findings 2, 3, and 4 extend this analysis by presenting several key ideas and themes related to practices and conventions of resource allocation in home care at the local level.

1. Growth in public funding for home care is not keeping pace with demand for services, and escalating costs of providing services, which limit the availability and provision of services.

We're getting to the point that we just need more help, period.

We've downsized, and downsized and downsized.

There is a strong perception among home care service providers that there has been an increase in case loads, increased acuity of patients, and an overall increase in demand for community-based services. This perception is consistent with the report of a district general manager:

Previously, three-quarters of the demand came from acute care and one-quarter came from the community. Now it's 50-50. We've had to shift this money.

The escalating cost of providing services also appears to influence the allocation of resources, particularly at the level of budgets.

Budgets are so fragmented. Everyone is trying to get costs off their budget, but to society I don't think it costs less. There is a growing incentive to get people out of hospital, but this may cost the system more in the long run.

In addition to community-based services, there has been increased demand for community-based services even within acute care hospitals. For example, in Saskatoon, the higher profile of the Coordinated Assessment Unit (CAU), which provides single point of entry assessment services

within the district, and the improved recognition of the services provided by case managers in the hospital, has led to an increasing expectation that the CAU can be called upon to solve discharge and placement problems.

> *Sometimes I get called because there's a bed crisis. The doctor will say: "I don't have a bed. I'd admit them if I did; [you] deal with them." My job is not to transfer acute care crises to community crises.*

The availability of human resources and the escalating cost of labour contracts for professional services are key issues related to resources. Saskatchewan has experienced a run of complex labour problems throughout the nineties and there is a clear consensus that the focus on labour relations and collective bargaining has been disruptive and has limited other activities. Recent collective agreements have changed the status of home health aides from casual to permanent. These new collective agreements, based on existing ones in institutions, have created scheduling difficulties which have escalated costs. In addition, new occupational health and safety regulations have been costly to implement.

> *10 years ago people looked to nursing homes and hospitals as best employers. Not anymore. The wages are still seen as good, the working conditions are still seen as pretty good, but the constant change and uncertainty makes people feel insecure.*
>
> *The collective agreements [i.e., for nurses] have changed the hours of work and changed how we can assign work. These cost more money, but there is no real improvement in services.*
>
> *In the last round of bargaining they agreed to things that can't be implemented. For example, in the Saskatchewan Union of Nurses [negotiations] they agreed there will be an out-of-scope manager always on call [in nursing homes] ready to respond to a crisis at all times. But we don't even have any managers living here.*

These labour tensions have influenced the way services are provided and resources are allocated:

> *We could get a lot more value out of nurses if physicians weren't the real keepers of the gate. But the rules haven't changed. Doctors still control the system. Some doctors simply transfer patients if they feel uncomfortable, even though they may be able to be cared for at home by experienced nurses. But the Licensed Practical Nurses are also suing the registered nurses, claiming that they're keeping them from doing the full scope of what they're trained to do. So the doctors don't let the RNs start IVS when they can, and the RNs don't let the LPNs start catheters.*

For example, in the past, home care aides were hired as casual staff, with no benefits and no regular hours. Now, when the shortage of personnel is even more acute, many of these casual workers are seeking employment elsewhere, where the conditions might be more favourable financially and more stable with respect to work hours, conditions and benefits.

> *We have shortages of nurses and health care professionals. We've been crippled by well-meaning people with no forward planning.*

The shortages of nurses, home health aides and licenced practical nurses has led to changes in personnel policies and practices within home care, such as combining nurses and home health aides into the same service department and altering some of the basic features of the contractual arrangements.

> *We're moving to guaranteed hour positions, away from casual hours. This gives us more control over scheduling, improves continuity of care and improves our monitoring function and supervision. We also do extensive on-the-job training and education. The licenced practical nurses are now increasingly consulting with the nurses.*

Case managers consistently reported that the increased demand for services strained their ability to provide services and prevented them from applying their specialized skills and knowledge to the best of their ability.

> *Whether or not services that people need are available when people go home, there is a limit on how much service people can get, whether they are available and how soon you can set them up.*

> *The high case load limits your ability to attend to people's needs. You don't get to everyone, there's no time for evaluation of the effectiveness of what you're doing, like avoiding readmission. It takes away your ability to be pro-active for clients. This is very frustrating. Personal morale suffers. You feel that you're doing an inadequate job.*

These creeping constraints have resulted in more rigid and restrictive policies and a feeling among case managers that their ability to exercise their professional judgement and discretion has been curtailed. As one case manager put it, "*Common sense has disappeared*".

> *Over the last 5 years, home care has been moving toward standardization of services. This affects our decision-making as well. Now I know what exceptions won't be accepted, that is there is less room for exceptions and negotiation.*

In general, it appears that there are not sufficient resources within the 'formal' system of community-based services to meet all the demand. However, there was considerable variation, even across demographically similar districts, with regard to their fiscal deficits and capacity to respond to demand for services. Some districts reported that funding and lack of resources have not yet had a significant impact on their ability to provide services.

> *We haven't really had any problems with funding or lack of resources in our district yet, though I know lots of other districts have.*

It's not clear that we don't have sufficient resources. Some of the facilities [e.g., local hospitals] may not be as necessary as people may think. If this was private industry, we'd make harder decisions or, in the end, we won't have anything.

Another problem, identified by many case managers and managers, is the rising expectation of what home care services can achieve for clients. Increasing demand for acute care substitution due to increasingly restrictive admission and aggressive discharge policies at acute care hospitals, coupled with the shortage of long term care facilities, has resulted in enormous pressure on the home care sector.

We have an increasingly aging population with more demand on long term care and home and case managers are feeling the brunt of that.

We don't get funding commensurate with the expectations that are placed on us...Because of huge expectations for acute care in the home, there is more and more pressure to keep people in their homes.

This is particularly evident in how case managers deal with people who might "fall through the cracks". Such people include those with limited informal supports, those who do not meet eligibility criteria for service, those for whom appropriate publicly-funded service is not available, and those who refuse service and are at risk.

A lot of times the resources are there, but it's difficult to service people who don't fit the mold.

This situation has been exacerbated by the loss of "soft services" such as stand-alone home management (SAHM—house cleaning for individuals who do not have other health-related care/service requirements), which intensifies the need to look at other solutions.

If keeping someone at home only requires a couple hours per week of cleaning, well gosh, I can't believe we won't do that. I've seen patients in chairs cleaning floors, very determined to manage as much as they can.

SAHM was also seen by many case managers as a reasonable and inexpensive way to monitor certain patients and to prevent accidents and/or undue deterioration in certain clients. In resource allocation terms, it had previously provided a third option between "formal" services and no "formal" services.

In the past, home management was the easiest to put in, because it's least intrusive, so we don't get them early and spot problems before they get bigger.

Managers also recognize the potential benefit of SAHM in establishing initial contact and fostering relationships with clients who may otherwise be extremely wary of interventions such as bathing,

for example, clients with mental illness. With the new policy, SAHM is not available, on its own, to play this type of role.

> *A trust relationship develops from home management that may let you get other things done. For example, a client with mental illness may refuse bathing, which would also let them get SAHM.*

Whereas case managers were comfortable with the level of monitoring that SAHM services used to provide for certain clients, they must now actively seek and develop other individuals and/or service providers to play this monitoring role (or some variant on this role). Despite the many concerns expressed by managers and case managers alike over the loss of SAHM, home care managers report that the loss of these services does free up home care staff for other services, such as increased respite care.

2. The lack of resources requires case managers to function as gatekeepers for the system, a role that can conflict with their roles as service providers and client advocates. These conflicts can create binds that must then be resolved.

Case managers have to wear two hats. They view themselves as patient advocates, but they also appear to take their role as 'gatekeepers' seriously. Several case managers said that they must be advocates for clients and advocates for the system, i.e., they must take active steps to prevent deterioration of the system due to unbridled utilization. Case managers appear to share similar aims in the provision of services, though these are clearly constrained by the reality of finite resources:

> *We try to optimize resource use, while optimizing [client] independence, while minimizing risk [to client]. We should be able to move with the clients' needs.*

Case managers highly value client choice and autonomy, but are also attentive to the disempowering effects of excessive dependence. Thus, case managers do not equate providing service with client empowerment.

> *The other part of our job is to empower clients and their families, which may not necessarily mean giving them service, but rather to get them to problem solve through negotiating and facilitation.*

The strong commitment to individual choice and autonomy also means that case managers must accept that clients may also choose to live "at risk", i.e., that they will refuse services that the case managers deem appropriate. This appears to be accepted well by case managers in general, though they do not appear to stop looking for ways to monitor, and/or benefit the clients in other ways.

> *She's living at risk, but that's where she does better. You can't keep everyone safe all the time.*

In some cases, the skills of "case management" alone provide a sufficient balance between denying services and providing them indiscriminately. For example, a case manager who provides case management services in the emergency room of an acute care hospital reported that families are not always receptive to the idea that patients, who are in medical need, should not be admitted to hospital, a problem that she helps patients and families explore:

> *I ask people to verbalize their needs and how they can get their needs met. I don't tell people what they need, that's not my job. People don't necessarily need home care. They may not need any other services at all other than case management.*

This case manager, and many others, reported that patients and their families often struggle with the suggestion that the "system" may not be the most appropriate source of solutions for their health related problems. There is also the prominent view among case managers that clients should be encouraged and assisted to be independent and self-sufficient, wherever possible. This stance influences the way case managers allocate services, for example,

> *I sometimes get clients who feel unable to care for themselves. In those cases I prefer to initiate minimum care so that it's easier to wean them off.*
>
> *My role is to get the client to think about re-allocating their resources, their orientation to the problem, their emotional response to reconsider the nature of the problem and to re-think what they really need.*
>
> *I try to maximize my clients' ability to be independent and to access services at their own schedule. For example, teaching regarding self-care. Ideally this is for acute care, but it would be nice to start teaching and training in hospital or pre-hospital.*

Concern and advocacy for the system function at various levels within the system. First, at the level of judicious utilization of services by an individual case manager within a program, for example,

> *The hard thing is taking services away once the need has passed. People don't usually like this.*

A second level of advocacy has to do with concern about features of the system or policies that give rise to incentives to shift costs from one's personal program to elsewhere in the system, even if the overall cost is higher:

> *I am conscious that there is a limited amount of money in the system. Therefore, we should emphasize activities that promote patient independence, rather than shifting cost elsewhere.*

A third level of advocacy for the system is embodied in mechanisms for resolving conflicts related to disputed decisions, and supervision of case managers. Most home care programs appear to have mechanisms to permit decisions to be appealed by clients (or by case managers). Many case

managers reported that they appreciate these mechanisms, since they provide them with the opportunity to advocate strongly in favour of clients, but also provide some insulation in cases in which services are ultimately denied, i.e., the decision is not perceived by the client as emanating from the case manager. It appears that the appeals panels seldom overturn the judgements of case managers, which strengthens the notion that case managers can advocate effectively for the interests of their clients.

The examination of guidelines and eligibility criteria that occurs through the process of the appeals mechanisms also contributes to the on-going assessment of decision-making guidelines. As well, supervisors reported that one of their roles is to provide a "peer review" process to ensure the appropriate allocation of services.

> *For example, some case managers respond to client wants in a way that obscures the needs...Specific cases inform the interpretation of the eligibility criteria. It's like the common law, the cases and the process of interpretation lead to refinements of criteria.*

In Saskatoon, the Coordinated Assessment Unit and Home Care have a joint committee, the Service Utilization Review Committee (SURC), that is used to examine patterns of service utilization and to determine whether utilization falls within the scope of existing policies, guidelines and practices. Before issues are brought to the SURC, CAU case managers have direct consultation with home care supervisors. This function is all the more important because of the basic mechanisms of assessment and service provision.

> *This involves difficult juggling, since the CAU case managers can order services, but these services are paid for by Home Care. The services don't come out of the CAU budget. We use a system of cooperative case management for coordination of services and delivery and management of services.*

These appeals and oversight process appear to be more common in larger urban areas, where population and services are more concentrated. As well, in rural areas, there may be different community dynamics that might make appeals less likely, and a level of transparency and publicity in the community that itself serves as an important level of scrutiny in practice.

A fourth level of advocacy is experienced and practised at the level of upper management, e.g., in the activities of the regional or district managers. One participant spoke at length about the "collective responsibility (of regional managers) to contribute to the overall integrated function of the district" in order to "save the whole Saskatchewan health system".

There are some instances in which the "binds" experienced by case managers also have a public profile. For example, a recent policy to eliminate stand alone home management (SAHM) services did not require removal of these services from clients who had qualified for them under the previous policy. In some cases, neighbours may have similar levels of need, yet be receiving different levels of care. The subtle issues related to "grandfathering" existing policies are often not fully understood

or appreciated by clients, who simply see unfair distribution of services. This can be frustrating for case managers, but can also lead to erosion of trust by clients.

Another source of frustration for case managers involves the general aims of service provision. This is felt most acutely in the case of SAHM, and is intensified by the lack of conclusive evidence about the contribution of these services to the "health" of clients.

> *I believe that most elderly people really do try hard to manage. If people feel good about themselves, if they're happy in their home and they feel safe where they're living, that contributes to their quality of life.*

In some cases, case managers will "play the system". For example, they might increase care plans to ensure that patients also get cleaning. Case managers reported that patients would "need to be close" to needing other services, such as bathing, in order for the case manager to "inflate" the care plan, i.e., they "wouldn't just invent the need". Other tactics reported by case managers were blocking discharges from hospital by requesting consults, which delayed discharge for patients they thought were not ready to go home, or accentuating the worst-case scenario in their assessments with the hope of achieving a different level of services for a given patient. One case manager reported that admission to nursing homes appeared to be easier for patients with particular conditions.

> *The case managers used to joke amongst each other that incontinence would get you into a nursing home.*

These tactics were characterized as "gaming" by some case managers and as "dishonesty" by others. In either case, the case managers appear to be trying to maximize the benefit they can achieve for individual patients within the constraints of the system. It is important to emphasize, however, that none of these activities appears to serve the personal interests or benefit of the individual case managers, and in that way at least these differ significantly from other instances of "gaming" in society.

There were many reports of conflicting policies regarding funding and/or eligibility that appear to emanate from cutbacks and the drive to reduce cost. For example, a case manager from the Twin Rivers district described a case of a 93 year old man who had been discharged from a local hospital but who was not feeling well. His wife called to say that he was really sick and did not know what to do for him. The man could not be admitted to hospital and there was nothing else that he was eligible for locally:

> *We had to put him in a dedicated respite bed in [a town that was not easily accessible for his wife]. He really got sick and we were doing acute care in the respite bed for over a month. What do you do with this person?*
>
> *You're supposed to be trying to get people out of the hospital, but you can't guarantee what you're sending them into.*

If there are no beds for them to go to, we have to keep them at home as long as we can.

In more remote rural areas, the options appear to be fewer and the alternatives are likely to impose a different type of hardship on patients and their families:

The distances are hard on patients. If you send someone to Saskatoon, it places a huge burden on families.

Yet some of the geographic issues are also evident locally. For example, the divisions of districts that accompanied regionalization can also impose arbitrary divisions within communities and can prevent people from seeking services in certain familiar areas.

Some folks live in high rises here, but they farmed in [town, which is across the district divide], so they can't access services there.

3. Administrators recognize that case managers can not find all the tools and resources they need within the public system and must often seek solutions outside the system envelope, beyond publicly-funded services to private services, and to informal caregivers, family members, neighbours and the community at large. Innovation and creativity are required to identify and mobilize these resources.

Even in districts that have experienced more acute resource constraints, it appears to be a rare occasion in which case managers cannot achieve some resolution to a client's immediate service needs.

We seem to have the flexibility to create options.

We have lots of frustrations, but I also think we do have some flexibility in the system to shift resources.

If the resources or "tools" required by the case managers to provide appropriate services for their clients do not exist within in the 'formal' system (or exist in insufficient supply), the necessary people or services can often be found within the community, either on a contractual or volunteer basis.

The first responder program [lay volunteers get trained in CPR, first aid, etc.] was developed in response to downsizing.

In rural areas, to provide heavy care it's almost impossible to do that without some family or neighbour support...we seek solutions wherever we can.

You have to be very resourceful. It's your responsibility to open up all kinds of windows for families, such as home care, private funding and insurance, you must understand the available options in great detail.
The guidelines are there so you know what you can give this person. We know what we have to work within. Anything out of that, we know is where the work begins.

The most compelling example of "working outside the envelope" involved a case manager from Twin Rivers who sought a raised toilet seat for one of her clients, who was unwilling to pay the full listed price for the item. The case manager knew a woman in a nearby community who had purchased a raised toilet seat, but who had not used it. The case manager approached this woman and offered to purchase the toilet seat at a reduced rate and to pass on the savings to her other client. At some point during their discussion it came to light that the woman who needed the toilet seat raised chickens. The case manager negotiated to acquire the seat in exchange for two of the other woman's chickens.

Understanding of the "available options" increasingly involves looking to services provided outside the publicly financed system to for profit organizations in the private sector, a situation that many case managers find troubling:

I get frustrated with colleagues who don't provide people with all the options, that is public and private. A lot of my colleagues don't think beyond home care.

We've moved along the continuum from public to private. Now, more often, we look to the private sector for resources. It's unfortunate, now the Health District is focussed on how do we get people off our services.

There is interest among case managers in alternative funding models that may provide clients more control over the service choice.

We are looking at models of money following the client. This would allow individuals to have more control...and would allow an exploration of more private options. It allows people to determine from their own perspective what will constitute "benefit" for them. Client-centeredness only occurs when you achieve something that the client wants.

The availability of services within the private sector raises yet another dilemma related to allocation of services, the implicit means test:

I priorize based on risk to the individual and the caregiver, on the nature of the services required, for example nursing services and symptom management get a high priority, but I also priorize based on the ability of the client and caregiver to access other services. For example, if they have money to pay for services, they may get a lower priority (for insured services).

Generally speaking, [informal means testing] is not acceptable, but it's also hard to reconcile wealthy folks who want the cheapest services, versus going into a home where people are eating dog food.

Another dimension in the move "outside the envelope" of the publicly funded system, is the increasing reliance on, and conscious utilization of, friends and family members in the care of patients at home.

Now the focus is to draw the caregivers in as much as possible. There are situations in which it is O.K. and others where this puts an inordinate stress on the caregiver, who is already doing a lot.

The reality for many families is that the caregivers are themselves elderly and not capable of providing the level and intensity of care required by the patient.

You really need some help just to be 82, never mind giving someone else help

The innovations and creativity demonstrated by the case managers appear to be understood and largely appreciated by managers. Although there was some acknowledgement that managers and case managers may have different perspectives in terms of what they are trying to achieve for the client and the system, there was strong recognition of the complex task facing case managers in the current climate and appreciation that too many rules and regulations can also limit case managers' ability to solve problems.

Rules can tie people's hands, so that innovative ideas are stifled.

The process of seeking practical, local solutions to the immediate problems faced by case managers appears to facilitate the development of community at various levels: between client and care providers, between client and neighbours, among service providers. Case managers achieve this through extensive horizontal and informal communication.

I have a lot of informal linkages. If someone is not available, I can connect with someone else.

Home health aides are a big part of creativity. Sometimes we discuss and it's amazing We have a good mixture of people. You scratch my back and I'll scratch yours.

The 'system envelope' includes the funding arrangements, services, human and other resources available within the publicly funded system. As demand increases for these services and resources, case managers must devote more time and energy to locating and mobilizing other sources of these services/resources.

In the rural setting, there are not the same number of providers to draw from. Much of the care is delivered by privately contracted individuals.

Other districts have very stringent criteria and guidelines for providing services; we have resisted that. If a client needs a service and there are no alternatives, we will provide the service. What we focus on is very strong case management...the litmus test is not so much policy, but application of alternatives that are acceptable to the client. We take a holistic approach to client care. You don't want to say "because of policy, you can't get this service".

But case managers also work 'outside the envelope' *within* the system, i.e., they develop approaches that are outside the traditional conventions of the system:

We started a wheels to meals program where elderly people come to the nursing home for meals. These people couldn't previously access the home unless they were residents.

Yet despite the clear acknowledgement that constraints on resources are important in limiting service delivery, there was a surprisingly strong consensus that the problem is not simply one of inadequate funding and resources. Many case managers and administrators reported their belief that a lack of creativity and innovation in all aspects of service design, delivery and administration are at least as important factors in improving the system:

We don't need more money, we need more innovation. My biggest concern about the pressure on the system is the knee-jerk response. We might miss opportunities for durable and creative solutions out of the pressure to respond...We need to have an integrated approach to planning and problem solving. Everyone must be at the table and working towards a shared vision...Sometimes we change for change sake. We need to have a shared rationale for change and evidence and justification. Change must be centred on the interests of the client.

4. Case managers focus more on "building community" around the client through extensive networking and communication, than they do on allocating services among competing clients.

I will search out the good neighbour organization that can help out. I will seek out other community volunteer services without touching the system's money...Talking to the client to see if there is a neighbour, to call in, knock on the door every day - you've got to pull everything you can out of that person...Even churches, they're a community resource. There may be someone in the congregation who would be willing to make phone calls, maybe a neighbour can do it in the afternoon, maybe somebody from the quilting club that the client used to belong to might do it in the evening.

"Building community" takes many forms in the delivery of home care services. Particularly in the smaller rural areas, case managers often appear to be active participants in community groups, such as "Wellness Committees" that engage in health promotion activities at the local level:

There are community groups who are taking control and responsibility for health-related activities. They're making healthier communities. Some of the schools have picked up these programs and incorporated them into their curricula.

Communities don't have the mechanisms to make collective decisions. They also don't have the desire: "we want..., we want...", it's all about self concern. People in communities equate good quality care with having a doctor in the community. We were starting to get into the new community models [i.e. when they lost doctors], but then we got some doctors back and people are now less interested in the community.

5.0 DECISION-MAKING IN HOME CARE: NOVA SCOTIA

5.1 Context

The Coordinated Home Care Program was established in 1988 under the Ministry of Community Services, with administrative responsibilities shared with the Department of Health. The program was limited to persons aged 65 and older; services consisted of nursing and home supports targeted towards persons with chronic care needs. The Coordinated Home Care Program was replaced in June 1995, by a more comprehensive province-wide program called Home Care Nova Scotia. The current program is administered by the Nova Scotia Department of Health through the Regional Home Care offices in the four health regions (Central, Western, Northern, and Eastern). To date, the provincial home care program has not been devolved to the regional health boards (Health Canada, 1999).

Home Care Nova Scotia (HCNS) is mandated to provide acute care substitution as well as the prevention and maintenance services, often referred to as home supports. Provincial funding policy/planning and operations are conducted by two Program Directors in the Department of Health and Regional Directors who are responsible for the regional delivery of the home care services.

Responsibility for the In-Home Support programs that currently provide financial assistance to low income Nova Scotians with care needs was recently transferred to the Home Care Nova Scotia budget from the Department of Community Services. Currently, continuing care services are operating on parallel systems for home care and facility care. However, a single point of entry to continuing care for seniors is targeted for implementation by April 2001.

Home Care Nova Scotia is funded by a population needs-based formula. The legislative framework consists of the *Homemakers Services Act* proclaimed in 1981, and the *Coordinated Home Care Act* proclaimed in 1990. Discussions are currently underway to create a new "Continuing Care Act" as part of the overall strategy to integrate services.

The delivery of professional services (nursing) are through contractual arrangements with the VON (NFP) and the Department of Health (Public), the latter providing home care services to the rural populations in Nova Scotia. Market share for public nursing services are 20-25% and NFP 75-80%.

Community physiotherapy and occupational therapy services are not provided by the home care program, but are contracted through the hospitals or the Arthritis Society.

HCNS provides ongoing case management even after a client is admitted to a facility. The province endorses a generic model of case management, hiring both nurses or social workers. Nova Scotia is currently not using any automated data collection tool, however it endorses a needs based assessment.

Eligibility to access HCNS requires proof of residence in the province (and/or Canada). Prior to service being provided, a comprehensive needs assessment is conducted. If the client has a home that is safe and suitable for service delivery and has signed a consent then a care plan is developed in response to unmet needs (e.g., if sufficient help from family and friends is not available). Professional services are covered by the province, while eligibility for home support services is determined by an income assessment on a sliding scale to determine clients' financial contribution. Upper limit cost maximums for home supports are based on comparable costs to care for an individual in long-term care facility ($2,200/ month). Upper limits for acute home care costs is $4,000/month.

5.2 Summary of Key Findings

- Resource allocation decisions are greatly influenced by the lack of a defined "basket of goods" that should be funded under the public home care system. The lack of clarity has contributed to the growing distinction between, and boundaries established for, the provision of acute and chronic care services.
- The historical roots of the program and public perceptions of entitlement are major factors influencing resource allocation decisions.
- For home care staff, the decision-making process reflects an inherent tension between the fiscal realities and the ability to respond to client needs.
- An integral part of decision-making is the "process of negotiation" with clients, families and other providers. Negotiation however, is often hampered by the lack of system features such as information technology, evidence-based policy frameworks and provincial standards.

6.0 FINDINGS – NOVA SCOTIA

1. Resource allocation decisions are greatly influenced by the lack of a defined "basket of goods" that should be funded under the public home care system. The lack of clarity has contributed to the growing distinction between and boundaries established for, the provision of acute and chronic care services.

Many of those interviewed attributed the tension and confusion around resource allocation to the lack of defined goals and the "basket of goods" to be funded under the public home care system. The lack of empirical evidence and supporting policies has resulted in substantial variation in resource allocation decision-making at all levels. As competing demands grow in intensity, the lack of clarity and increased requirements to prioritize service needs has accentuated the tensions for staff and clients.

Without a clear definition of what should be publicly funded and the policies to support that definition, many case managers and administrators openly commented that there was flexibility in decision-making; "*policies that did exist were up for interpretation*". As a case manager, if is not possible to meet client needs within the conventions of home care you worked outside those conventions.

> *I have seniors on my case load who really needed personal care, but refused to take it. In order to build a level of trust I put in housekeeping for a month or so until the client feels comfortable and ready to accept the help.*

> *Some of the best work we do is around surveillance, education and monitoring, but there is no specific program for this so I'll put in foot care to monitor a client.*

> *Loneliness is a big issue for clients, sometimes the home support worker is the only person they see–is that so wrong? Loneliness can kill a person.*

To further stretch limited budgets other sources of funding are explored with clients. The concept that the liability for cost should be shared by the state, individual and insurance companies was a prevalent theme in the interviews. Most staff and administrators recognized that competing demands for limited resources meant looking for alternative and innovative solutions to ensure those most in need received services. However, case managers expressed concern over the increased pressure on families to pay for home care services and/ or take on the role of informal caregivers for families and friends, especially in the rural communities.

> *We're asking seniors to pay for home support services. For them, a small amount of money makes such a difference, they would rather go without and that could, and does have a negative outcome for the client.*

> *We're meeting the needs for a lot of chronic care clients. Our biggest help is to those that have a declining function such as arthritis clients who are really incapacitated due to pain. You could argue we should be doing more–but we won't get more money for it. There is a lot of confusion around the value of home supports.*

> *We have so much distance to cover with people in the rural communities that we have to rely on families and friends to provide care. We are told to augment families not the other way around.*

Home care is a last resort. I don't like that policy, it's hard on families.

Although delivery-system reform and improved quality of care in Nova Scotia were viewed as important, a critical goal of regionalization and decentralization in 1994 was budget control. The central theme of cost containment and rationing has prevailed and permeated the home care sector, having an impact on resource allocation decisions. Even though expenditures allocated to home care for Nova Scotia increased between 4% and 6% from 1996-1998, home care administrators and policy makers feel the investment has not kept pace with inflation and the growing elderly population, causing increased strain on budgets. According to one observer, the growth in the home care program is *"really putting limits on the number of people and the types of services that can be publicly funded"*.

These fiscal limits have led to a growing distinction between, and establishment of boundaries for, the provision of acute and chronic care services. The lack of evidence around who, what, when, and how long to provide chronic care, often referred to as home supports services, has resulted in confusion and tension on how best to allocate limited dollars.

The provision of acute care substitution services is often touted as the panacea to a health care system that needs to contain costs, reduce inappropriate hospital admissions, and facilitate earlier discharges from institutions. But as one observer noted, *"the erosion of social supports to enhance acute care services provision in the home, in my view, is contributing to earlier placement and more emergency and doctors visits"*.

If we continue to see the volume of clients increase and the budgets stay the same, social supports will decline. Nobody knows what direction the government will take on this issue, but it's clear to us that home support services are under scrutiny while meeting the needs of the acute care population is a must.

In an attempt to reduce the pressure of increasing demands on the system, clients who have the ability to pay are delayed in receiving services. According to one administrator, *"there is a tendency to place far less urgency on meeting the needs of clients who have the ability to pay for home supports"*. The delay in obtaining services has acted as an incentive for clients to seek services privately, thus taking some of the pressure off the public system. This phenomenon has not appeared to be a contentious issue nor has it created much debate.

In addition to having individuals paying for services where appropriate, there are clear expectations that third party payers (insurance companies) should be another funding source.
Case managers, however, stated that in the past few years insurance companies, as a source of funding, are restricting access to necessary drugs, oxygen therapy and professional services for clients who wish to enhance what the public system can not provide them.

Insurance companies are harder to deal with. They are quibbling about every little service provision.

Clients bought insurance as a safety net for future situations when they, or a family member becomes sick. You can imagine how upset they become when they realize that what they thought they were entitled to is no longer the case. It really makes me sick - everyone is getting out of the business of caring.

2. The historical roots of the program and public perceptions of entitlement are major factors influencing resource allocation decisions.

To understand the history of the home care program in Nova Scotia is to understand everything.

The history of the program and the key players in the system are reported as having a major influence on the types and choices of resource allocation decisions being made. The Coordinated Home Care Program (CHCP) available in the late 1980's was very much a social program serving the older population with a strong emphasis on home support services. According to one observer, the underlying philosophy of the program goes back even further to the Local Implementation Program (LIP), in which communities were given money to put in place any array of services the community felt were necessary. Many communities set up what today would be called home support services.

Even prior to the CHCP, communities banded together to provide services to people in their communities. This made a big difference in the rural communities where there was limited access to services. The community seniors would organize and provide the services, which could range from bringing water, chopping wood, or caring for your children if you were ill. To many, the emerging home care program threatened the essence of community. People didn't want to have strangers coming into their communities. You can see how this history would have a great deal of influence on what people expect from the current home care program.

The historical nature of the funding for acute care and chronic care services has also had a direct influence on the nature of resource allocation. Although home care is an extended service under the *Canada Health Act*, most provinces have maintained that professional services are to be insured, while social supports previously covered under the Canada Assistance Plan are cost-shared based on income testing. The consolidation of both the professional and social services in Home Care has created tension among clients, staff and program administrators on how best to resource those two distinct program areas. From a client perspective, the process of charging fees for services has often been stated as *"confusing and unfair"* once services moved from the Department of Community Services to the Department of Health. The perception that the services should fall under the province's insured program has endured.

Seniors have felt betrayed by the request for money and will often refuse to accept the services when they learn that fees are expected. They feel it should be covered.

After the "program" was no longer under the Ministry of Community Services and became part of the Department of Health's mandate, social supports weren't seen as essential–just a costly nuisance.

Many individuals interviewed stated that the change in the nature and scope of the program was not well communicated to staff or the general population.

At the outset, the program made promises to the general public that it just wasn't able to meet. Clients, generally seniors, were still of the mindset that the program was an "entitlement" that "just got better" when the new program was introduced. This perception has been difficult to change.

In the beginning everyone got what they wanted, it seemed no one was denied services. On the most part those services were to meet their social needs. After the program review in 1995 we started asking what do we really need to be doing and for who? By then it was too late, we all had grandiose ideas and expectations on what the program could offer.

Our expectations, and the communities expectations were not well managed from the beginning.

The senior population have been "slow to adapt" to this new model of home care. We have historically been seen as 'molly maid'. Clients want and expect to have their standards of housekeeping maintained.

3. The decision-making process reflects a tension for home care staff between the fiscal realities and the ability to respond to client needs.

Are we here to save the government money or serve the client?

It became evident in the interviews that resource allocation decisions often reflect the interviewee's commitment to juggling fiscal prudence with responsibility to the client's needs. It was commented by those interviewed, however, that in many cases, home care staff tended to lean more towards decision-making for the greater benefit of the client. 'Hard choices' have had to be made. Moreover, *one of the biggest frustrations is not being able to get the clients the services they need.*

Equally frustrating to many, has been the response to fiscal pressures. *The route we took . . . we're on it now. We're fitting round pegs in square holes - just doesn't work.* There is also variation amongst case managers and their supervisors. *"There's inconsistency of supervisors regarding getting extra hours for clients, they all see it differently".*

On several occasions we heard of home care staff being 'creative' with their care plans to ensure that clients received the necessary services.

As a manager you start to recognize what the limitations are, but there are always creative ways to try and meet the needs of the client.

We bend a lot of things [policy] to make it easier to do it and provide better care for the clients.

Budget constraints force you to look at other options and be creative.

With regard to respite, for example, *What we'll do is find other non-respite tasks that mean someone must be there, so that respite can still continue.*

4. An integral part of decision-making is the "process of negotiation" with clients, families and other providers. Decision-making and ultimately negotiation however, is often hampered by the lack of system feature such as information technology, evidence-based policy framework and provincial standards.

Negotiation is a primary component of a care coordinator role.

Throughout the interviews it became apparent that a key role of home care staff is communicating and 'negotiating' with clients and their families as a way of more clearly identifying the possibilities for care that appeases both the fiscal realities of HCNS and the regions, and the needs of the clients and their families. Indeed, negotiation is regarded as important enough that one of the regions offers a 2-day negotiation skills workshop.

Home care is regarded as the 'last avenue'. As such, care coordinators often engage in a process of negotiation with the client and/or family member as they must look at alternatives first before considering home care. These alternatives include families taking on caregiving responsibilities, or friends and neighbours, or deciding to pay privately for care (and perhaps in some cases through insurance). In any case, home care staff must work with the clients to look at the options available. This requires considerable communications and inter-personal skills, and is perhaps a poorly recognized role that is played to address the current fiscal realities of today. And in some cases, the staff must be bearers of bad news when some clients are no longer eligible for services.

Clients are not happy. But that's the policy. It's not easy to tell them that.

Many times you say 'I am the messenger. I don't make the rules but that's the policy'.

Generally, if you're persistent, you'll get what you need [from the clients].

In some instances negotiation may be as simple as assisting a family work through who will be responsible for ensuring a door is open for a home care staff. In other cases it can become quite complex as the care coordinator works through the daily life commitments of family members while

also working with other government departments to see if various arrangements can be made to ensure the appropriate level of care is provided to the client.

At the same time home care staff must be wary that some people will endeavour to game the system and manipulate the workers so that they can receive more or longer care (e.g., a client feigning illness when the home care worker arrives, only to be seen later in the day fully active). Several anecdotes were shared with us to that effect.

The ability to skilfully negotiate was also mentioned as critical when dealing with other sectors and physicians, many of whom, it was stated, have differing perceptions as to what home care is, and should be. *"Their understanding of home care is not great"*.

A number of system features that are felt to facilitate decision-making and ultimately resource allocation were identified in the interviews as currently lacking in home care. These include information technology, evidence-based policy frameworks and provincial standards. Collectively the lack of supporting infrastructure and instruments for decision-making have served to heighten the level of uncertainty in home care and have made it difficult for some to deal with allocating resources.

> *Resource allocation decisions are not based on knowledge but guesses.*

> *We're struggling in this province because we don't have good information technology. How do they make any decisions when we don't have good information?*

Competing demands and pressures from the system, families and co-workers have also made it extremely difficult for case managers to standardize their approach to resource allocation decision-making.

> *We need clarification of policy and guidelines, it's really needed. I would make different choices if my decision was backed up by policy. Then, at least, I would know that everyone is being treated in the same way, it would be fair.*

7.0 DISCUSSION

The findings in the two provinces illustrate a range of interrelated issues affecting the nature and extent of resource allocation decision-making in home care. Broader health system issues such as lack of integration and coordination, de-instutionalization, and limited funding, place pressures on decision-makers in home care. The historical context also plays a role in shaping the mind set of those both working in the system, the system itself, and the views of the recipients of care.

The responses to system pressures reflect the ongoing, and increasing challenge of balancing fiscal constraints and client needs without adequate information or research to inform decisions. Through a process of negotiation, coupled with an implicit and explicit approach to building community

outside the publicly-funded envelope, home care staff have been able to develop creative ways of meeting client needs with limited resources. The need for systematic policy and decision-making is evident, but so too is the desire for a system which still provides flexibility for allocating resources unrestrained by rigorous and detailed policies and guidelines, and which confers some degree of choice for clients requiring care.

The prevailing paradigm of resource allocation in health care draws from the clinical scenario in which there are more patients with a particular need, e.g., for organ transplantation, than there are available organs. The "model" involves highly specific needs, e.g., to unblock heart vessels, which require highly specific products and/or procedures, e.g., angioplasty stents. In these circumstances, the products and/or procedures cannot be further subdivided and therefore individual recipients must be selected. Therefore in these circumstances resource allocation requires withholding potentially beneficial treatment from certain patients in favour of others for a wide variety of reasons, but usually on the basis of a combination of efficiency, i.e., likelihood of benefit, and need, i.e., urgency, level of incapacity, risk of death, etc.

The clinical "model" or paradigm of resource allocation does not fit the data collected about home and community-based care in Saskatchewan and Nova Scotia. When presented with an example of resource allocation in the clinical setting (e.g., angioplasty stents), the case managers who we interviewed seemed to find the framing unfamiliar and inflexible. Specifically, the case managers appear to have rejected the premise that there are insufficient resources available and/or that the available resources are not further divisible (the central premise in the clinical model) and instead, employ creative and proactive strategies to identify available resources within the community. This does not mean, however, that the case managers thought that there is always an adequate supply of resources. Rather, the needs that they deal with are less absolute and the risks of harm less clearly predictable than in the clinical model, while the services are more divisible and malleable and the forms of service provision are more varied and flexible.

A more accurate characterization of case managers' views of resource allocation might be "building community around the client", where community can cover a wide range of "services" from high intensity technical nursing services to house cleaning and grocery shopping. These services are not only offered by publicly-financed service providers and private, for-profit service providers, but can also be 'developed' by volunteers in the community at the family or neighbour level. Therefore, the constraints that case managers experience in the community context are more diffuse than those in the clinical setting, though they are no less pervasive.

"Allocation" also has a different meaning from the clinical context. In the community, "allocation" refers to the on-going process of *identifying* available resources, *mobilizing* them, *directing or supervising* their activities, *negotiating* the appropriate terms or circumstances under which the "resources" may be utilized, *training* and *teaching* and *monitoring* progress or effectiveness. This set of skills and tasks—which is essentially the skill set required by case managers—reflects a far more complex sense of allocation than simply prioritizing on a narrow set of factors, as occurs in the clinical context.

This re-framing of resource allocation has implications for the way we view the problem of priority setting and resource allocation in community-based care. In particular, it challenges us to examine the core requirements of justice in this context, which appear to go far beyond the factors of fair distribution that are familiar in the clinical paradigm. However, before we have a strong consensus regarding what we are trying to achieve for clients and their "health" through the provision of community-based services, it may well be impossible to determine the fairest and most reasonable approaches to allocating the available resources.

8.0 SUMMARY

The findings may be summarized by looking more precisely at the meaning of resource allocation in the community context. "Resources" in this context can be interpreted as referring primarily to human resources, particularly those with the requisite basic physical and intellectual capabilities to provide care for others (increasingly difficult, for example, for elderly neighbours or family). However, "resources" also refers to products and commodities required to deliver care effectively in the home, for example, the lack of availability of machines for home oxygen (even if sufficiently skilled support staff are available) will limit the ability to provide this service to a client with the requisite need. Finally, "resources" also refer to broader aspects of the available community infrastructure, such as spaces for day programs for elderly clients with dementia. The above discussion points captures the notion that the traditional concept of resource allocation, which has an emphasis on discrete, indivisible products/ services/ and incentives does not appear to fit the home care resource allocation pattern, which is less discrete and more divisible than the clinical paradigm infers. Therefore, the terms "resource" and "allocation" both have quite different meanings from use in the clinical context and must be further examined in the home care setting to develop its own typology of evidence.

Without a clear vision, or a comprehensive account of the goals of home care (e.g., to ensure fair equality of opportunity), it will be extremely difficult to define what should be part of the publicly-funded home care system in Canada. The end result is uncertainty regarding which services will achieve poorly articulated ends, and continued frustration for clients and front-line workers.

Clearly there needs to be clarity in the goals of home care that are both philosophically and practically sound to meet the diverse needs of clients requiring acute and long-term care substitution, as well as the maintenance and prevention aspects of the program. The debate on what should be an insured service requires an open and transparent public process to ensure that resource allocation decisions in the future are guided by a framework and foundation of participation by all stakeholders affected by the decision.

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