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"Expanding the Principle of Comprehensiveness from Hospital to Home": A Submission to the Standing Committee on Social Affairs, Science and Technology, July 17, 2002

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Abstract

The purpose of this brief is to outline a series of financing, delivery and organizational mechanisms that extend the spirit of the Canada Health Act to health services and technologies that were previously provided within a hospital setting, but are now available to Canadians where they reside. To achieve this goal, three principles are invoked: first, reforms should be introduced in a phased manner with supports that further service integration; second, the comprehensiveness principle captured in the Canada Health Act should be broadened to include necessary health care wherever that care is sought, delivered and received; and finally, mechanisms that constrain government liabilities should be included in any reform package.

Following an introduction, Section 2.0 outlines the development of home care in Canada, with an emphasis on expenditure and financing trends, and the associated policy context that has enabled the development of the new health care order. In Section 3.0, home care is framed as a service that complements and should be integrated with services available in other health care settings. In Section 4.0, mechanisms for the financing, delivery and organization of post acute home care are described. Estimates of the total cost of a National Post-Acute Home Care Program are provided in Sections 5.0, and a brief conclusion with recommendations is offered in Section 6.0.

While an array of home-based health care services are currently provided to a range of home care recipients, including chronic and continuing care, pre-hospital care, and post-acute care, this brief focuses on post-acute home care (PAHC) as the first stage in the development of a National Home Care Program. A focus on post-acute home care extends the reach of the Canada Health Act, and improves its relevance to contemporary health care. Moreover, an emphasis on such care advances the principle of service integration, as communication between hospital and in-home service providers is essential to advance the efficient and effective allocation and use of health care services.

The establishment of a geographically separate and organizationally distinct funding program for PAHC is not recommended in this brief. It is argued that a separate, parallel National PAHC Program may inhibit service integration across networks of care and may limit opportunities to enhance the efficient, effective and equitable allocation and use of health care services.

Estimates of the cost of PAHC, and associated “hidden costs” including drug expenditures, range from $1,021.1 million to $1,511.8 million (in fiscal year 2002 dollars). If the federal government were to cost-share these expenditures on an equal basis with the provinces, then the federal share would range from $510.6 million to $755.9 million.

The following recommendations are presented, with the aim of enhancing service integration and ensuring that Canadians have necessary health care, irrespective of where such care is sought, delivered or received:

Recommendation 1: Post-acute home care recipients should be defined as individuals who received their first home care visit within thirty days of their inpatient or same day hospital discharge date.

Recommendation 2: An episode of PAHC should be defined as all home care services received

between the first date of service provision following hospital discharge, if that date occurs within thirty days of discharge, and up to one year following hospital discharge, for those without use of home care prior to hospitalization.

Recommendation 3: Clinical groupings for PAHC recipients should be sufficiently small that they enable the derivation of stable utilization rates for PAHC. Use of Major Clinical Categories (MCCs) and Day Procedure Groups (DPGs) satisfy these criteria.

Recommendation 4: Estimates of the mean cost of PAHC should be used to develop financing estimates for a National Post-Acute Home Care Program.

Recommendation 5: Financing for PAHC should be first directed to hospitals, but the PAHC envelope should be monitored on a regular basis to ensure the appropriate provision of such care.

Recommendation 6: To encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a rate-based method of reimbursement for PAHC should be developed in conjunction with rate-based arrangements for each episode of hospital care.

Recommendation 7: Do not restrict the range of services, products and technologies that may be used to facilitate the use of home care following hospital care.

Recommendation 8: Provide out-sourcing opportunities to hospitals so that they have the option to develop contractual relationships directly with home care service providers or with transfer agencies that may provide case management and service provision arrangements.

Recommendation 9: If contracts were formed with home care service providers, these contracts should include, in addition to rate-based reimbursement arrangements, mechanisms to monitor service quality and performance.