

Home Care in Canada: Passing the Buck

Peter C. Coyte, MA, PhD.

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Correspondence and reprint requests:

Dr. Peter C. Coyte, Professor of Health Economics and Co-Director, Home Care Evaluation and Research Centre (HCERC), Department of Health Administration, McMurrich Building, 12 Queens Park Crescent West, University of Toronto, Toronto, Ontario, M5S 1A8, Canada. Phone: 416-978-8369; Fax: 416-978-7350; and Email: COYTE@CHASS.UTORONTO.CA

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Executive Summary

This paper provides: an overview of Canadian home care services; it highlights health policy assumptions that have resulted in an increasing reliance on in-home services; and it assesses roles for the private and public sectors in the financing of home care services.

Home Care Expenditures Growing Relative to the Health Sector:

Dramatic growth in home care expenditures have occurred in the last twenty five years. In the last decade home care expenditures have increased at a rate that was fourfold greater than other health spending, 9.0% vs. 2.2%. These figures are indicative of the increasing emphasis on home care services. Such expenditure growth is attributable to expanded beneficiary eligibility, increased accessibility, technological change, health system restructuring, and the aging and longevity of the population. However, a key motivating factor is the belief that cost-savings may be realized by redirecting care away from institutions towards the community.

Inter-Provincial Variations in Home Care Expenditures:

A three-fold inter-provincial variation in home care expenditures per capita were reported after adjusting for the composition of the population. Such funding variations, when unrelated to the health and social needs of the population and the availability of alternative sources of support, raise concerns about access to home care services, treatment appropriateness, and health system and informal caregiver costs. These funding variations highlight opportunities to ensure that all citizens of Canada, irrespective of where they reside, have equal access to appropriate services.

National Standards: A Role for the Federal Government?

The federal government has an important role to play in highlighting variations in home care expenditures and may even have an obligation to rectify such variations, when the need arises, through the introduction and enforcement of national standards for home care. Such standards might include many of the same principles that currently exist for those services privileged under the Canada Health Act (CHA). Moreover, the development of national standards for medically (and possibly socially) necessary services, irrespective of the health care setting in which such services are sought, received and delivered, is a natural extension of the principles of the CHA to ensure that

it is relevant to the health system of the new millennium. Such standards might include a basic basket of services and a floor or base for public coverage.

Public and Private Home Care Expenditures

While there has been a lack of information describing the extent of private home care finance, estimates were derived based on data acquired from three national in-home service providers. These estimates suggest that private home care finance is approximately 25% of public home care finance. Moreover, if past trends in home care expenditure growth were to continue, home care expenditures would reach \$3.4 Billion in fiscal year 2000/2001 (FY00) of which \$2.7 Billion would be derived from public sources and \$0.7 Billion from the private sector.

Demographic Trends and Home Care Utilization

The elderly and women exhibit higher rates of home care use than other Canadians. Changes to the age-gender composition of the population will exert a significant upward impact on home care expenditures. Inflation-adjusted home care expenditures are expected to grow by 80% between 1999 and 2026. By 2026, the share of home care in total health expenditures is projected to exceed 10% of total spending.

Assumptions Driving Health Policy Change

Restructuring has moved the health care setting from hospitals to the home, and has shifted the emphasis away from physicians as care providers to caregivers in the home setting, including family and friends, nurses and personal support workers. Since passage of the Canada Health Act (CHA) in 1984, the share of health expenditures covered under the principles of that Act have fallen from 57% of total spending to 45.5%.

Dramatic change in the setting for health care has been driven by three major policy assumptions that require critical scrutiny. First, Canadians want to assume substantially greater responsibility for health care at home. Second, housing and employment circumstances permit the shift of safe and effective care to the home, and finally, safe and effective care at a lower cost will result by shifting

care to the home. Since each of these assumptions have yet to be definitively or consistently verified, Canadian health policy continues to be pursued in an informational vacuum.

National Home Care Program

Wide variations in home care funding highlight opportunities to address potential inequalities in access to home care services. While almost \$700 million is warranted to ensure residents in all regions of Canada have equivalent levels of funding for in-home services as residents of Ontario, it is more difficult to obtain agreement on: national standards for the range of publicly insured professional and home making services; and the precise terms and conditions of public insurance, including eligibility conditions, service plans and cost-sharing arrangements. Until such issues are squarely addressed, it is unlikely that progress will be made on a national home care program.

Options for Home Care Finance: Reallocate; Enhance Revenues; Reduce Liabilities

Modifications to the age structure of the population, enhancements to wealth and socio-economic status for older Canadians, reductions in the supply of informal care, and a preference for greater choice and tailored health servicing will add to pressures to (publicly or privately) finance the increased provision of in-home services.

The response by government to the increased demand for formal in-home services may be threefold: first, to continue the process of health reform and to shift health resources within health care towards the home and community care sector, reallocate; second, to increase public health finance from the broader economy through higher levels of taxation or reallocated spending from other priorities such as debt reduction or tax cuts, revenue enhancement; and third, to lower outstanding health financing liabilities, reduce liabilities through expenditure containment exercises. Each of these options is associated with various costs and benefits.

While a range of home care financing options exist, tax-based incentive schemes for the provision of informal care and to enhance savings for home care needs represent likely avenues for future consideration that satisfy the political and economic calculus for sustainability. However, concerns

abound with respect to their consequences which suggest that careful and in-depth review be undertaken before implementation.

1.0 Introduction

The funding, organization and delivery of home care services have become prominent health policy issues. Home care services compete for scarce financial resources with other health system stakeholders. Despite this competition, home care programs have enjoyed broad appeal, have experienced dramatic expenditure growth, but still represent less than 5% of total health spending.

Many factors account for the growth in home care expenditures, including expanded beneficiary eligibility, increased accessibility, technological change, health system restructuring, and the aging and longevity of the population. However, a key motivating factor appears to be the common belief that significant public sector cost-savings may be realized by redirecting care away from institutions towards the community.¹⁻³

While there has been a dramatic increase in home care expenditures, there is currently no common national definition for such services. In many jurisdictions, under the home care service designation, an array of agencies and providers participate in the provision of a complex range of health professional and lifestyle enhancement services to a variety of clients.⁴⁻⁶ The range of service categories is large and includes nursing, social work, physiotherapy, speech language pathology, audiology, occupational therapy, meals on wheels and home-making. While most clients receive these services to prevent or retard the deterioration of health and to assist them to maintain independence in the community, other clients receive a more specialized variety of rehabilitation services following an acute care hospitalization.

The purpose of this paper is threefold: first, to provide an overview of the growth in Canadian home care services; second, to highlight health policy assumptions that have resulted in an increasing reliance on in-home services, whether provided through formal or informal channels; and third, to assess the roles for the private and public sectors in the financing of home care services. Home care is used to illustrate a general shift towards an enhanced role for private financing of health care services. While the Canada Health Act (CHA) has historically privileged hospitals and physicians, shifts in the setting in which Canadians receive services and products have resulted in an increasing

reliance on private health service finance. Shifts in responsibilities for caregiving and financing Canadian home care are the focus of this paper and are likely to remain key health policy issues through the twenty first century.

In Section 2.0, home care expenditure trends are reviewed within the context of health expenditure inflation and shifts in the public and private finance of health care. In Section 3.0, home care utilization is explored and considered within the context of dramatic change in the age-composition of the population. Following these reviews of home care expenditure, finance and utilization, Section 4.0 examines the impact of recent policy shifts that have placed significant emphasis on home care services as an alternative to institutional care. The impacts of the shift in the setting in which health care is sought, delivered and received are explored from multiple perspectives and raise questions with respect to public-private cost shifting, equitable access to cost-effective services and the impact of in-home provider competition on the costs and the quality of care. Confronted with an increasing emphasis to shift (or devolve) responsibilities for both caregiving and financing to the private sector, and in the light of the associated consequences to Canadians, Section 5.0 examines the potential roles for the public and private sectors in the financing of Canadian home care services. Section 6.0 offers a brief conclusion.

2.0 Home Care Expenditures

Home care expenditure trends are discussed within the context of total health expenditure inflation and dramatic change to the age-composition of the population. After a review of past trends, home care expenditures are here projected to the year 2026.

Home Care Spending is Increasing Faster than Other Categories of Health Spending

Figure 1 portrays the dramatic growth in public home care expenditures in Canada, using Health Canada's definition of such expenditures, see Appendix. Since fiscal year 1975/1976 (FY75), public home care expenditures grew at an average annual rate of 17.4%, increasing from \$62 million in FY75 to \$2,096 million in FY97. This period of dramatic home care expenditure growth masks two discrete growth periods, FY75 to FY92 and the period since FY92. Between FY75 and

FY92, home care expenditures grew at an annual rate that was almost double the growth in total health spending (19.9% vs. 10.8%). Since FY92, home care expenditures have continued to grow, but at a rate that was fourfold greater than that for other health spending, 9.0% vs. 2.2%. These figures are indicative of a dramatic and increasing emphasis on home care services.

While home care expenditures have increased, less than 4% of national spending was directed to that sector in FY97. Figure 2 reports inter-provincial variations in the share of public health expenditures devoted to home care and demonstrates that New Brunswick, Ontario and Newfoundland have the largest shares (at over 5%), while Prince Edward Island and Quebec have the smallest shares, at less than 3%.

Wide Inter-Provincial Variations in Home Care Spending Exist

Figure 3 reports inter-provincial variations in per capita home care expenditures. These variations persist even after adjusting for the composition of the population in each region. While Canada as a whole devoted \$69 per capita to home care services in FY97, there was almost a three-fold variation in spending by comparing New Brunswick, Newfoundland, Ontario and Manitoba to Quebec and Prince Edward Island. Such funding variations highlight opportunities to ensure that all citizens of Canada, irrespective of where they reside, have equal access to appropriate services.

The federal government has an important role in highlighting home care expenditure variations and may even have an obligation to rectify such variations through the introduction and enforcement of national standards. Such standards might include many of the same principles that currently exist for those services privileged under the Canada Health Act (CHA). Moreover, the development of national standards for medically (and possibly socially) necessary services, irrespective of the health care setting in which such services are sought, received and delivered, is a natural extension of the principles of the CHA to ensure that it is relevant to the health system of the new millennium. Such standards might include a basic basket of services and a floor or base for public coverage.

At least five main factors account for the wide inter-provincial variations in home care expenditures. First, variations currently exist in the level of total health spending. Such variations alter the means available to allocate scarce provincial resources to all sectors, including home care services. Second, there are inter-provincial variations in the emphasis on the home as the setting for health care. In some jurisdictions, other settings, such as community clinics, geriatric day centres, etc., are used more extensively than in-home services. Third, inter-provincial variations in the age-gender composition of the population, the availability of community supports and the social context in which in-home services may be provided, alter in-home service needs. Fourth, since there have been variations in the speed and extent of health system restructuring across the country, each region is at a different stage in its emphasis on home and community services. Finally, since home care expenditures are defined as the product between the cost of in-home services and the number of services provided, a portion of the inter-provincial variation may be attributable to each of these two components of total spending.

Variation in standardized home care expenditures, when unrelated to the health and continuing lifestyle needs of the population, client preferences and the availability of alternative sources of care and support, raise concerns about access to home care services, treatment appropriateness, and both health system and informal caregiver costs.^{7,8} Moreover, such variations highlight opportunities to improve home care funding mechanisms to ensure that all citizens, irrespective of where they reside, have more equal access to home care services.

The Share of Private Health Finance has Increased

It is informative to consider home care expenditure trends in the broader macro-context, and particularly, by distinguishing between CHA expenditures, that is, expenditures on acute care hospitals and services provided by physicians, and non-CHA expenditures, which includes home care services. Within these categories, it is also useful to distinguish between public and private health expenditures, which depend on whether various levels of government were the source of finance or other sources. Public CHA expenditures would thereby include government expenditures on physician and hospital services. Private CHA expenditures would include private supplementary

coverage for hospital and physician services, etc. Table 1 reports public-private financing for various categories of expenditure categories in 1975 and 1999. The Table demonstrates that annual expenditure growth for non-CHA services have been greater than that for CHA services, 9.3% vs. 7.2%. Since non-CHA services currently account for over 90% of private expenditures, it is not surprising to find both an increase in the private share of health expenditures and a higher rate of expenditure growth in the private sector in comparison to that in the public sector. Specifically, while the private sector accounted for 23.6% of total health spending in 1975, it today accounts for 30.4% of total spending.

Growth in Non-CHA Spending Accounts for Half of the Growth in the Private Share

There are two distinct factors that account for the growth in the share of private finance in total health expenditures that have rarely been distinguished in the literature: finance- and service-specific expenditure growth. The former concerns the differential rate of growth by source of finance (public vs. private), while the latter concerns the growth rate differential for specific service categories, irrespective of the financing source.

Table 1 demonstrates that growth in the private financing sector has been greater than that in the public sector, 9.6% vs. 8.0%. While this differential exists for both CHA and non-CHA expenditures, the data do not apportion this increase to growth in unit prices and that due to the growth in the volume of services. Consequently, inferences with respect to efficiency and servicing between the public and private sectors cannot be made on the basis of these data.

Table 1 also illustrates that non-CHA service expenditures have increased faster than CHA expenditures, 9.3% vs. 7.2%. While service-specific expenditure growth (non-CHA vs. CHA) accounts for a portion of the rise in the private share, an equally important growth factor is the differential rate of expenditure growth between sources of finance (private vs. public). If expenditure growth between sources of finance were identical and if the growth of CHA and non-CHA service expenditures were 7.75% and 9.30%, respectively, (mid-way between those in the private and public sectors), the private share of health finance would have increased to 27.6% in

1999¹. Consequently, approximately half of the growth in the share of private finance is attributable to service-specific patterns of expenditure (cost shifting or passive privatization) and half to the higher rate of private sector expenditure growth (expanding markets or active privatization).

Recent debate with respect to the upward trend of the private share in total spending has attributed this growth to a realignment of health service expenditures from CHA services to non-CHA services. However, the estimates developed in this Section suggest that this realignment of health service expenditures only partially accounts for the increased private share. The remainder is attributable to the combined effect of higher unit prices and greater client servicing in the private sector.

Private and Public Home Care Service Finance: How Large is the Private Sector?

In the last 25 years, there has been dramatic growth in total health expenditures which have increased at an average annual rate of 8.5%. However, this increase is pale in comparison to that recorded annually for public home care expenditures, 17.4%. While home care expenditure growth has been attributed to many factors,⁹ there is a lack of information concerning the extent of private financing.

The only information concerning the extent of private finance for home care services has been derived from surveys of household expenditures. Two surveys warrant consideration. First, a survey conducted by PriceWaterhouseCoopers,^{10,11} based on responses from over two thousand Canadians, indicated that 25% of home care clients report average out-of-pocket expenses of \$407 per month on home care and \$138 on prescription drugs. (These expenditures represent almost 15%

¹ Based on the defined annual growth rates in CHA (7.75%) and non-CHA (9.3%) expenditures, private expenditures in 1999 would have been \$2,068.7 million (\$344.9 m. X 1.0775²⁴ for CHA expenditures) and \$21,585.2 million (2,554.3 X 1.093²⁴ for non-CHA expenditures). Similarly, total public expenditures would have been \$61, 914.8 million. Consequently, the share of private expenditures in total spending would have been 27.6% ((\$2068.7 m. + \$21,587.2 m.)/\$85,568.7 m. Thus 4 percentage points (27.6 - 23.6) of the 6.8 percentage points (30.4 - 23.6) is attributable to service-specific expenditure patterns (passive privatization) and 2.8 percentage point is attributable to the higher rate of private sector expenditure growth (active privatization).

of the average annual public home care expenditures per client in Ontario, see Section 3.0.) In addition, home care clients recently discharged from hospital spent approximately \$200 per week on home care services. Second, a survey conducted by We Care Health Services,¹² an independently-owned home care provider, based on responses from 33 of its 58 offices across Canada, found that home care clients incurred 24.5% of the cost of nursing services and 59.3% of the cost of home support services. Average weekly out-of-pocket expenditures by home care clients were estimated to be \$283. While efforts are required to ensure the reliability of these expenditure estimates, they offer at least some estimates of the extent of private home care finance.

In order to obtain more precise information on the extent of private home care finance, confidential data were provided by three national in-home service providers (Comcare Health Services, The Victorian Order of Nurses for Canada and We Care Health Services), that detailed each organization's public and private revenue sources. While there was some variation in the public sector revenue share between organizations and more dramatic inter-provincial variations, approximately 80% of each organization's total revenue was derived from the public sector. If this share were maintained across all home care provider organizations, private finance for home care services in FY97 would exceed \$500 million and total (public and private) home care expenditures in FY97 would be \$2,620 million.

Conclusion:

If past trends were to continue, total home care expenditures, whether privately or publicly financed, will reach \$3.4 Billion in FY00. While home care spending has grown faster than other categories of health spending, wide inter-provincial variations in home care expenditures persist, the extent of private finance is believed to be large with Canadians facing significant financial barriers to accessing in-home services. Notwithstanding these pressures, federal and provincial home care policies continue to be pursued in an informational vacuum. Much of the health policy commentary is speculative, because evidence to objectively evaluate alternative methods of financing, delivering and organizing in-home services is absent.

3.0 Home Care Utilization

In the absence of national data on home care utilization by age and gender, this Section examines patterns of utilization in Ontario. Two dimensions to utilization are examined: first, the home care utilization rate, which measures the number of home care clients per 1,000 population; and second, the intensity of home care utilization, which measures the number of home care services or level of expenditure per home care client.

There were 261,635 clients who received at least one in-home service funded through provincial home care programs in Ontario in FY95, the most recent year in which client specific data were available. The age-gender distribution of these clients is reported in Figure 4. The majority of home care clients were women (60.1%). Almost 50% of men receiving services were under 65 years of age, while only 35% of women were in that age group. Almost 20% of male clients were under 20 years of age, while that age category accounted for less than 10% of female clients.

The Elderly and Women Are the Main Users of Home Care

Figure 5 depicts home care utilization rates per 1,000 population by age and gender. While the number of clients under 65 years of age is large, their utilization rate is small, <2%, compared to persons over 65 years. Women exhibit utilization rates that are more than 20% higher than those for men. The observation that home care rates increase with the client's age and were greater for older women than men may reflect increased service needs for both the elderly and single-person households who may have limited access to informal supports.

Figure 6 reports the intensity of home care utilization by the age and gender of home care clients by depicting per client home care service expenditures. While average expenditures per client were substantial at \$2,736, expenditures for clients under 20 years of age were approximately 60% of the provincial average. In contrast, the intensity of home care utilization by clients older than 85 years of age was more than 20% greater than the provincial average. The intensity of home care use grew with the client's age and was higher for women older than 45 years than for men.

Demographic Trends: What Effect On Home Care Expenditures?

Changes to the age-gender composition of the population are likely to exert a significant upward impact on home care expenditures. In this sub-section, preliminary estimates are presented of the effect of demographic change on home care expenditures.

Figure 7 portrays information from the Organization for Economic Cooperation and Development (OECD) on two demographic dimensions for member countries. Namely, the proportion of the population over 65 years and the proportion over 80 years. In 1999, Canada had a relatively young population, with residents over 65 years of age accounting for 12.4% of the population, while less than 3% of the population were over 80 years. Poland had the youngest age-structure of its population, while Sweden had the oldest age-structure.

Statistics Canada has developed population projections to the year 2026 under varying assumptions concerning fertility, mortality, immigration and migration.¹³ Table 2 reports medium growth projections for the Canadian population. This table demonstrates that the Canadian population is expected to grow at an average annual rate of 0.6% over the next twenty six years, while the population over 65 years of age is expected to increase at an average annual rate of 2.7%. This projection suggests that by the year 2016, 21.5% of Canadians will be over 65 years of age and more than 5% of the population will be over 80 years, as shown in Figure 8. Canada, along with Japan and Australia, are expected to age at a greater rate than other OECD member states. Moreover, this dramatic aging of the Canadian population will make today's Swedish population look relatively young.

To assess the effect of demographic change on home care expenditures, data from Ontario on utilization and information from Statistics Canada on the age-gender distribution of the population of Canada for 1999 and 2026 were used. These figures yielded estimates of the impact of demographic change on home care expenditures under the traditional, though rarely explicit, assumption that current age-gender adjusted utilization rates remain unchanged. Demographic

change is associated with population growth and changes to its age-gender composition. These two effects were associated with a 78.4% total increase in home care expenditures between 1999 and 2026, yielding an average annual increase of 2.2%.

Demographic change is expected to have a profound effect on the home care sector even if current utilization rates were maintained. The magnitude of the effect is enormous. Specifically, in the absence of further health system restructuring and without modifications to institutionalization rates, inflation-adjusted home care expenditures will grow by almost 80% by 2026. Such growth is likely to increase the share of home care expenditures in total health spending to double digits by 2026.

4.0 Health Policy Shifts: Assumptions and Consequences

In this Section, the main health policy assumptions that have resulted in an increasing emphasis on in-home services as an alternative to institutional care are outlined. In addition, the impact of these policy shifts on Canadians are highlighted.

Modifications to the setting in which health care is sought, delivered and received have profound, diverse and complex effects for an array of stakeholders. Moreover, recent changes to the setting in which care and support are received have serious implications for: medical and social practice; training opportunities; and the role of household circumstance in aiding recovery and health maintenance. To date, the study of health care settings has been a much neglected area of health services research and health policy discussions. In this Section, we demonstrate that "Place" is central to the study of the health care continuum and in the framing of health research questions.

4.1 Health Policy Shifts

One of the major social changes of the last quarter century has been the shift in the setting for health care delivery from the hospital to the home. Yet, policy development and system restructuring are occurring with very little evidence that what we are doing is right. Moreover, assumptions about the benefits of home and community care have taken on the status of conventional wisdom. These

assumptions that have formed the basis for health policy shifts have yet to stand the test of critical scrutiny.

The federal government, on the advice of the National Forum on Health, has explored the possibility of extending public insurance to home care. To advance this extension of federal involvement into areas of provincial jurisdiction, decisions must be made concerning: the terms and conditions of public insurance, including the range of insured services (social/medical), the duration of coverage (acute/chronic), the setting for service provision, and an array of financial considerations, including the scale of deductibles, the size of co-payments, the level and means by which service providers are reimbursed, and the amount of funding to ensure equitable access to high-quality care. In addition, appropriate methods for allocating public funds for in-home services and mechanisms for the advancement of cost-effective service provision are required.

While federal and provincial governments debate the issues around who will have responsibility and accountability for the setting of home care standards and whether these will be tied to funding arrangements, other stakeholders have more pressing issues. Policy makers, insurers, health managers, and health providers urgently need evidence regarding the costs and consequences associated with the provision of home care services in order to inform policy development and practice. Without such information to facilitate evidence-based decision making,¹⁴⁻¹⁸ health reform may result in more, not less, costly patterns of practice, and erode, not enhance, health and lifestyle outcomes.

That change is occurring, no one can deny. In Ontario, to take a provincial example, while inflation-adjusted per capita Ministry of Health (MOH) spending fell by 5.6% between FY91 and FY99, there were more dramatic changes to other health spending categories. Specifically, inflation-adjusted per capita acute care hospital expenditures fell by 19.7%, equivalent physician expenditures fell by 16.7%, while home care spending grew by 70.9% and all other categories of MOH spending grew by 20.3%.

Restructuring public health finance has moved the health care setting from hospitals to the home, and has shifted the emphasis away from physicians as care providers to caregivers in the home setting, including family and friends, nurses and personal support workers. The Canada Health Act (CHA), from its inception in 1984, has privileged care provided by physicians and care provided in hospitals. However, in just the last sixteen years, the share of total health expenditures covered under the principles of that Act, ie expenditures on hospitals and physicians, have fallen from 57% of total spending to 45.5%.¹⁹ As such, the CHA applies to the minority of health spending. While most provinces have chosen to publicly fund a component of home care, the shifting setting for care (combined with the current form of the CHA) has opened the door to a possible major reallocation of health costs from the public to the private realm, thereby eroding what has become recognized as one of the hallmarks of Canadian identity. The key policy questions that remain include what will be the base level of public coverage and the extent of cost-sharing (i.e., public with co-payment, or private payment) and fully private services in the home care sector.

4.2 Assumptions Driving Change

Health care practices have radically changed in the recent past and a broad spectrum of formerly publicly funded services are now delivered in the home. There are wide variations in the availability, accessibility and quality of home care throughout Canada. While there is a urgent need to address the informational vacuum with respect to health management and policy formulation, recent health policy directions have been associated with three commonly-held assumptions that require empirical verification.

First, it is believed that Canadians want to assume substantially greater responsibility for health care delivery at home; that they want to be discharged from acute care early; that they want to remain in the community rather than be residents of long-term care facilities; and that their family and friends want to provide informal care. However, there is considerable concern about the potential burden placed on family members and friends associated with the provision of informal care at home. Moreover, the advent of the "sandwich generation", who must care for both children and elderly

parents, raise doubts about whether conventional assumptions about the supply of informal care are appropriate for the new millennium.²⁰

Second, it is further assumed that Canadian housing and employment circumstances permit the safe shift of effective care to the home. However, even the finest modern home was not designed to facilitate the long-term provision of care and may indeed, be a hazardous environment both for clients and in-home providers of informal and formal care. More complex and technically sophisticated care is being conducted in the home, but we do not know whether family members are able to cope safely with these changes. Moreover, given evidence that indicates that informal caregiving has historically been performed by women, changes to patterns of labour force participation and other competing demands on time raise questions about whether the same supply conditions persist for informal care.

Finally, it is commonly assumed that equal or better care at a lower cost will result by shifting care from institutions to the home. Although there are few empirical studies evaluating the benefits of home supports, a recent report released by the Health Services Utilization and Research Commission found that Saskatchewan seniors receiving preventive home care were 50% more likely to lose their independence or die than those not receiving any services. In addition the average total health service costs for preventive home care recipients were about triple the average costs for non-recipients. Residents of seniors housing were 63% less likely to lose their independence and 40 % less likely to die than other Saskatchewan seniors. Residents of seniors housing has about the same total health service costs as non-residents.^{20a} Notwithstanding this recent study, reviews of the international literature and in work conducted for Ontario's Health Services Restructuring Commission,²¹⁻²³ very little compelling evidence was found to document this assertion.²⁴⁻²⁶ The research, to date, has been of limited quality, with few studies applicable to Canada. The literature which has evaluated home care services has been of limited quality²⁴ and has yielded diverse cost and outcome estimates.²⁷ Differences in study populations, lack of randomization, failure to control for confounders, small and sometimes subtle treatment effects, limited samples sizes and short term follow-up periods account for some of these inconclusive results.

None of the dominant issues and assumptions that are driving health policy have been adequately tested, especially within a Canadian context. Since each of these assumptions have yet to be definitively or consistently verified, Canadian health policy continues to be pursued in an informational vacuum. The time is now ripe for governments to provide resources to acquire evidence to either support or reject these commonly-held assumptions. Only through evidence to fill the current informational void can we bring Canadian health care (and health policy making) into the new millennium.

4.3 Regional Variations In Utilization

Wide geographic variations in the use of many medical and surgical procedures have been noted.²⁸⁻
³⁰ These variations, when unrelated to the needs of the population, raise concerns over access to care, cost and the appropriateness of treatment.^{7,8}

Measures of intra-provincial variations in home care utilization were first reported in Canada for the period from FY93 to FY95 by Ontario's Health Services Restructuring Commission²¹⁻²³ and in three recent publications.^{9,31,32} These variations concerned the use of home care services following hospitalization, whether same day surgery or an inpatient stay. Irrespective of the methods used to measure regional variations in home care utilization, there were moderate to substantial area variations even after adjustment for the demographic composition of the population.^{9,21-23,31,32}

While the use of home care follows a similar pattern of variation as that reported for many health care services,^{9,22,33} more information is required to track the extent of such variation, to assess its determinants and to measure the resulting consequences for Canadians. While there have been various organizational and financing reforms designed to advance fair and more equitable access to an array of services, the impact of these reforms, such as the introduction of Community Care Access Centres (CCACs) in Ontario,³⁴ have yet to be comprehensively reviewed.

Equity Based Home Care Funding for Canada, the Provinces and in the Territories

Wide variation in home care expenditures, as discussed in Section 2.0, highlights opportunities to alter funding arrangements to ensure that all citizens of Canada, irrespective of where they reside, have equivalent levels of funding for insured in-home services. To achieve this objective requires a more equitable funding arrangements that allocate funding to regions on the basis of the characteristics of the area residents.

Home care funding estimates were derived for the provinces and territories to ensure that residents in each jurisdiction receive funding for the same range of insured professional and home making services as those currently available to Ontarians.³⁵ Ontario was used as the baseline for home care funding for two reasons. First, data were available on patterns of home care use and unit costs by age and gender, and second, Ontario was in the upper range of per capita home care expenditures. The estimates presented herein should not imply that the current level of home care expenditures in Ontario and its allocation across alternative in-home care providers is appropriate. Rather, the data provide a baseline for comparison and an estimate of the increase in public home care finance needed to ensure all Canadians have equivalent funding for in-home services.

Table 3 reports actual and projected home care expenditures in FY97 for all Canadian provinces and territories. The projections were based on three ingredients: the demographic composition of the population in each region;³⁶ the relative intensity of home care expenditures by age and gender in Ontario; and Ontario's per capita expenditure on insured in-home services. The funding variance measures the percentage increase in expenditures needed to ensure that all Canadians have equivalent levels of funding for insured in-home services as residents of Ontario. A negative variance, such as that reported for Newfoundland, indicates that current levels of public funding are more than adequate to offer residents the same level of services as those in Ontario. A positive variance demonstrates that current funding is lower than that available to Ontarians.

Given the wide variation in home care funding in Canada, it was not surprising to find substantial shortfalls in home care funding. Funding in both Prince Edward Island and Quebec was less than

50% of that required to ensure equivalence with current funding levels in Ontario. Even in Alberta, British Columbia and Saskatchewan, home care funding would need to increase by approximately 50% to match funding levels in Ontario.

The estimates reported in Table 3 suggest that an increase in home care funding of almost \$700 million is warranted to ensure that residents in all regions of Canada have equivalent levels of funding for insured in-home services as those currently available in Ontario. While this is more than a 30% increase in public home care expenditures in Canada, it represents only a 1.3% increase in total public health expenditures and a 0.9% in total public and private health expenditures.

Wide inter-provincial variations in home care funding highlight opportunities for federal and provincial initiatives to address potential inequalities in access to home care services. Of course, implicit in the projections developed in this Section is the belief that: uniform access to home care funding irrespective of where Canadians reside is appropriate; that national standards be developed outlining the range of publicly insured professional and home making services; that common eligibility conditions be designed for in-home service provision; and that common servicing plans be devised once the eligibility is determined.

While it is relatively straightforward to increase funding for the provision of home care services, it is much more difficult to obtain agreement on what range of services to publicly insure and to determine the precise terms and conditions of public insurance. Until these issues are squarely addressed at the national level, it is unlikely that progress will be made on a national home care program.

4.4 Home Care Service Cost-Effectiveness

Health managers, providers and policy-makers have been frustrated by the lack of data concerning the costs and consequences of in-home services.^{3,24-26,37} This lack of evidence means: managers are limited in their ability to undertake evidence-based decisions; home care health professionals and providers are limited in their ability to practice evidence-based care; and federal and provincial

policy makers are limited in their ability to develop evidence-based health policy. The absence of appropriate tools to enhance practice, to manage service provision, and to evaluate performance and policy development, may yield decisions that are neither congruent with the best interests of clients nor the cost-effective utilization of scarce health care resources.

Little is known about the impact of home care services on health and lifestyle outcomes or the extent to which the burden of care has shifted from institutions to patients, families and community agencies.²⁴ While home care expenditures have increased, this increase has occurred without compelling evidence of service cost-effectiveness.^{24,25,38} Moreover, there is a growing perception that unless these services are targeted towards specific client groups they will not represent a cost-effective alternative to institutional care.³⁹⁻⁴²

Two recently heralded studies concerning the use of home care following hospitalization⁴³ and as an alternative to facility-based long term care⁴⁴ suggest that home care may lower costs without adversely affecting the health of Canadians. While neither study used randomization to identify the unique contribution of home care services, both studies did suggest that cost savings might occur through modifications to health service delivery and organization. However, before embarking on radical health system change, more evidence is needed to confirm these preliminary results.

4.5 Home Care Provider Competition

An array of organizational arrangements exist for the provision of home care services. In some provinces, health care services are delivered by public employees, while other jurisdictions contract-out such services to either not-for-profit or for-profit agencies.⁶

In Ontario, Community Care Access Centres (CCACs) receive funds from the province to underwrite the cost of in-home services. Since the introduction of organizational reforms in 1996, the CCACs have withdrawn from the direct provision of in-home services. Each regionally-based CCAC is responsible for assessing client eligibility, setting service requirements, selecting service providers, monitoring performance and paying providers. Under these arrangements, in-home

service providers are expected to have an equal opportunity to provide services on a competitive basis.

One consequence of these reforms to the organizational structure of home care programs was increased competition between in-home service providers for contracts with CCACs. In principle, competition takes place on two dimensions, price and the quality of care,³⁴ with CCACs responsible for negotiating contractual arrangements with in-home providers.³⁴ While one objective of the reforms was to ensure fair and equal access to services across the province,³⁴ another objective was to increase provider competition in order to lower service costs and improve health and lifestyle outcomes.

The health services research literature has offered little compelling evidence of the costs and consequences of provider competition. The absence of valid and reliable outcome (or quality of care) indicators for in-home services necessarily implies that the full impact of provider competition falls on the price for in-home services. As the home care sector is labour intensive, a lower price for in-home services entails lower wages and benefits for nurses and other caring personnel. Such remuneration reductions add to recruitment and retention problems. Moreover, wage and benefit reductions erode on-the-job moral, and consequently, may adversely affect the quality of in-home care. These observations have recently been echoed by the Registered Nurses Association of Ontario⁴⁵ who also suggest that competition results in the delegation of tasks to unregulated providers and reduces the number of in-home visits received by care-recipients.

There has not been a comprehensive evaluation of the impact of provider competition on the home care sector, however, anecdotes abound. More evaluation and research is required to identify the practical consequences of in-home provider competition and to assess the domain over which competition may occur. Before advocating for increased provider competition and before recommending further organizational reforms, more evidence is required to inform health management and policy making of the consequences of existing reforms. The domain over which competition takes place, the effects of for-profit and not-for profit organizations on service cost and

quality, and the overall impact of competition on service cost-effectiveness warrant in-depth inquiry.

5.0 Options for Home Care Finance

Although health care is a provincial concern, the seeds of federal involvement, and more specifically in the setting for health care, were sown in 1948 with the National Health Grants Program.⁴⁶ This program accounted for the construction of over 90% of Canadian bed capacity by 1970 when it was phased-out.⁴⁷ Once the health grants program had laid the physical infrastructure for the development of public health insurance, the Hospital Insurance and Diagnostic Services Act of 1958 was passed which specified the terms and conditions of federal cost-sharing by place of service, namely hospitals. Following the introduction of federally-sponsored hospital insurance, the Medical Care Act of 1966 specified financing arrangements by type of care provider, namely physicians.

By 1984, specific health care settings and care providers were implicitly woven into the Canada Health Act, which replaced the Hospital Insurance and Diagnostic Services Act of 1958 and the Medical Care Act of 1966. Five major criteria had to be met by the provinces and territories if they were to qualify for their full share of federal transfers: comprehensiveness, universality, portability, public administration and accessibility. Accessibility was a new concept and it was operationalized as reasonable access by all residents to the full range of insured services without financial impediments to utilization.^{48,49} Since insured services were defined by the setting in which health care was received and the role of the care provider (namely hospitals and physicians), the Canada Health Act was implicitly confined to such facilities and care providers.

Health systems are always in a state of evolution, but in last two decades we have witnessed a tidal wave of change that has swept across most components of the health care system and come to rest upon the shores of the home and community care sector. Health care services are increasingly mediated by portable, miniaturized and user-friendly technology. Moreover, the internet offers a

new arena for the acquisition of health service information and a new setting for the provision of such information. We are, indeed, at the dawn of an entirely new era of health care, eCare.

The recent period of dramatic change has had an enormous impact on care-recipients, their families and friends as well as on in-home service providers, but this period of change is just the beginning of a new era which will see the return to in-home care, just as the home was the setting for health care in the last century. Moreover, modifications to the age structure of the Canadian population, enhancements to wealth and socio-economic status for older Canadians, reductions in the supply of informal care by families and friends, and a preference for greater choice and tailored health servicing will add to pressures to finance the increased provision of in-home services by formal care providers.

Conceptual Framework for Health Finance

One of the many challenges to be faced in Canadian health care, in general, and in home care, in particular, lies in the generation of a solution to the health financing optimization problem. Briefly stated, this optimization problem is composed of two sub-problems. The first problem is associated with the development of an appropriately weighted objective function for decision making. This objective function is likely to be composed of two distinct, though sometimes, inter-dependent arguments: efficiency; and equity. The former is concerned with service cost-effectiveness, while the latter is associated with distributional considerations. While each argument is important, health policy developed on the basis of only one of those arguments is unlikely to merit sufficient support from Canadians. Consequently, while the policy choice set may be wide, the set of feasible policy options is more limited. But which policies are pursued, depends on the emphasis or weighting placed on each argument within the resulting objective function. Again, the devil (and the direction for health system finance) lies in the detail.

Once an appropriately weighted objective function for decision making has been achieved, the second component to the optimization problem concerns the selection of public and private

financing options that optimize this function, subject to the constraint that sufficient revenue is collected to finance health service provision.

Individual and Collective Financing Options

Application of this framework to home care financing options offers two clear paths forward. The first emphasizes individual choice and is concerned with individual finance at the point of utilization or through an array of insurance, savings or pension arrangements. This approach to home care finance may be described as a "going-it-alone" or "walk alone" approach to finance because it relies on individual decision-making with respect to the financing of home care services. The second approach emphasizes collective choice and is concerned with tax-based finance at either the federal or provincial level. This approach to finance may be described as a "stand together" approach in which individuals forego a degree of autonomy in return for collective choice and proxy decision making that is designed (among other things) to safeguard the interests of the less fortunate through risk pooling in a common public fund. Such models of collective or public choice are often based on a "behind a veil of ignorance"⁵⁰ approach to policy making because they explicitly incorporate distributional considerations to assist in the formation of public policy.

While an array of financing vehicles may attain each of the two extremal approaches to home care finance, most provinces have adopted a centralist position. Based on estimates presented in Section 2.0, approximately 80% of total home care expenditures were derived through various forms of provincial taxation. The remaining source of home care finance was derived from the private sector. Such private finance took the form of direct out-of-pocket payments at the point of utilization and payments derived as a result of insurance coverage purchased individually or through group plans.

Pressures to Reform Health Care

Given the pressures outlined in this paper for increased home care expenditures, federal and provincial governments face a series of difficult decisions with respect to health service finance and health funding. Specifically, provincial governments have already faced many difficult choices

with respect to system restructuring, but the estimates outlined in this paper suggest that these challenges will be on-going given the aging of the population, continued innovations in home-based health technology, and modified supply conditions from traditional suppliers of informal care. Moreover, if Canadian really wish to receive health care in the comfort of their home, and if they act as vocal and visible constituents, the pressure on governments to respond to the wishes may be more influential than other pressures for increased funding.

Governments face three choices with respect to health finance: first, to continue the process of health reform by shifting resources away from areas that have been privileged by the Canada Health Act and other provincial and federal legislative initiatives towards the home and community care sector; second, to increase public health finance through reallocation of budget surpluses or through higher levels of general or earmarked taxation; and third, to lower outstanding health financing liabilities that confront various levels of government.

Public Finance: Reallocate; Enhance Revenues; Reduce Liabilities

Each of the three options faced by governments (reallocate within the health sector, revenue enhancement, which is tantamount to a reallocation of resources in the broader economy, and reduce, ration or use other mechanisms to lower outstanding public sector health spending) are associated with various costs and benefits.

Reallocate Health Resources

To champion home care and to down-play traditional settings for health care is a direct challenge to what has become the medical elite or the health system establishment. Not surprisingly, the recent advent of economic growth has been associated with a concerted process of reinvestment in hospitals and physicians. To champion the underdog, and to reallocate funds to sectors that are likely to be significant health system players in the future (well beyond the next election) are activities that are rarely pursued by politicians.

Enhance Revenues

To increase public spending for health care implies a reduction in resources for other activities. However, the current fiscal and electoral reality is one of lower not higher taxation. Although the arrival of balanced budgets has offered Canadian federal and provincial governments a new set of options among expanded spending in health care, debt relief, and tax reductions. Throughout Canada governments of all political stripes are lowering tax rates and contemplating alternative roles for the public sector.

Reduce Liabilities

Explorations of the appropriate role for government have been the subject of intense discussion in many areas public finance, including health finance. These discussions have often been pursued in the context of programs that provide Canadians with entitlements. In health care, the prospect of dramatic growth in pressures to increase expenditures is a major concern to governments interested in reducing their outstanding liabilities. Several options exist to lower these liabilities, such as rationing or prioritizing access to scarce health resources. Policies designed to restrict access to entitlements affect all Canadians and are unlikely to succeed. At the individual level, such policies raise concerns and introduce uncertainty about access to needed services in a timely manner. Moreover, individuals confronted with the on-going costs of servicing the health sector, via taxation, combined with the prospect of fewer health benefits, due to restrictions in their entitlements, are unlikely to support such policy initiatives.

Policies do, however, exist that reduce the health financing liabilities of government and simultaneously, satisfy the political and economic calculus for sustainability. The provision of incentives for Canadians to withdraw from or voluntarily give up their health service entitlements would lower government liabilities. One such mechanism is a tax-deductible contribution scheme, such as a Registered Health Savings Plan (RHSP), that would provide Canadians with an opportunity to save for their future home care needs. This policy option is akin to existing retirement savings vehicles and is likely to meet with significant political support as it offers Canadians a direct subsidy of controllable proportions. The RHSP option would be straightforward

to administer and implement, and it also yields potential benefits to the financial sector to provide advise and counsel regarding investment options.

There are, however, several difficulties associated with the introduction of the RHSP option. First, for RHSPs to be successful in reducing government liabilities, Canadians need to "opt-out" or "exit" the public sector. Such opting-out may undermine the public health care system. Since the RHSP scheme is likely to be adopted by Canadians in higher income brackets, as the tax reductions are greatest for those with higher incomes, the public system would lose such Canadians. The loss of wealthy and well-connected Canadians, and the absence of their voice to advocate for better services and higher funding would exert a cost on all who remain within the public system.

Second, the use of a tax-deductible contribution scheme for home care finance represents a regressive form of taxation for Canadians. Individuals in lower income brackets would either be unable to contribute to a RHSP (yielding a subsidy of 0%) or would received a smaller percentage subsidy than Canadians in higher income brackets. By linking home care finance to a tax-based contribution scheme, multiple-tiers of finance would be institutionalized where the wealthy are afforded better financing options than the poor.

Finally, there are several other difficulties associated with the re-direction of health finance to the private sector, including the administrative burden associated with the use of multiple payers for health care and the potential asymmetry of information between care providers and individual care recipients.⁵² Single payer systems have a track record of lower administrative costs than multi-payer systems, and more progressive distributional consequences. The use of a single purchaser of health care services also has a greater potential to address information asymmetry than infrequent purchasing decisions by individual Canadians.

Other Policies

While greater public finance or enhancements to private finance are emphasized as extremal positions, there are many other policies that could be pursued that represent a centralist approach.

One option concerns the provision of incentives that may take the form of tax-based subsidies to informal caregivers. To the extent that such subsidies enhance the supply of informal caregivers, demands on the provision of formal in-home services may be reduced, thereby lowering or at least rendering expenditure neutral the outstanding liabilities for government.

6.0 Conclusions

In the last two decades, we have witnessed a tidal wave of change within the Canadian health care system that has swept across most components of the health system and come to rest upon the shores of the home and community care sector. This period of dramatic change has had an enormous impact on care-recipients, their families and friends and in-home service providers. Moreover, modifications to the age structure of the Canadian population, enhancements to wealth and socio-economic status for older Canadians, and reductions in the supply of informal care by families and friends will add to pressures to finance the increased provision of in-home services by formal care providers.

The federal government has an important role to play in highlighting and alleviating inter-provincial variations in home care expenditures through the introduction and enforcement of national standards for home care. Such standards may include many of the same principles that currently exist for those services privileged by the Canada Health Act (CHA). Such standards would also outline the terms and conditions of public insurance, including eligibility conditions, service plans, and cost-sharing arrangements. Moreover, there is a need to develop consensus with respect to medically (and socially) necessary services, irrespective of the health care setting in which such services are sought, received and delivered. Extension of the CHA to a wide array of health care settings and care providers ensures that it is relevant to the health system of the new millennium.

The manner in which a society addresses the needs of its elderly is often a reflection of the society's values. Canadians have demonstrated a preference for collective choice in the financing of those services covered under the principles of the Canada Health Act. However, home care - an area slated for dramatic health expenditure growth - lies beyond the Canada Health Act. While a range

of policy options exist to address the financing of home care services, tax-based incentive schemes for the provision of informal care and to enhance savings for home care needs represent likely avenues for future consideration, but concerns about their likely adoption also require critical appraisal.

Collective action in non-CHA covered services may require a new, and possibly CHA-complimentary, federal legislative framework to guide national standards in home care within the Social Union Framework. The careful balance of federal action between new program spending and selective tax-based incentive schemes will determine the extent to which home care in Canada achieves the same national standards which hospital and physician services now enjoy.

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Appendix

Health Canada's Definition and Methodology for Home Care Expenditures

Home care programs are defined as programs organized to coordinate and provide health care and supportive services to an individual in his/her place of residence.

Home care expenditures include nursing care and support services received at home because of an illness or a health condition. This approach excludes home support services offered to individuals for reasons other than health problems (e.g. social services).

Home care services include: assessment and case management (single entry point, information and referral); health care and treatment services (nursing care, physiotherapy, occupational, speech and respiratory therapy, nutritional counselling); personal support services (homemaking, personal care, meal services); minor home repair and maintenance; and social assistance services, social contact and security services (friendly visiting, telephone reassurance) when they are directed to a person because of an illness, a health condition or a health-related need.

Drugs, medical equipment and supplies (wheelchairs, assistive devices, hospital equipment for dialysis, etc.) are not captured in these estimates.

Respite services (providing a temporary break or relief for the caregivers - often family members - who are caring for an individual in their own home) are included as long as they are provided at home. Respite services provided by institutions, day care centres or group homes are not included.

Public sector home care includes home care expenditures funded by provincial, territorial and municipal governments, Workers' Compensation Boards and those made directly by the federal government (e.g. Health Canada's home care programs for First Nations and Veterans Affairs home care spending for veterans). Hospital-based home care is included in estimates.

Public home care expenditures were estimated by Health Canada using Public Accounts, Annual Reports, Main Estimates, special requests from provincial and territorial health and social services departments and the National Health Expenditure Database maintained by the Canadian Institute for Health Information (CIHI).

Source:

Policy and Consultation Branch: Public Home Care Expenditures 1975-76 to 1997-98: Fact Sheet.
Health Canada: Ottawa, March 1998.

Table 1: Public-Private Financing of Various Categories of Health Expenditures

	CHA Expenditures *	Non-CHA Expenditures	Total
Public 75	\$ 7009.3m (74.9%)	\$ 2351.6m (25.1%)	\$ 9360.9m
99	\$36852.8m (61.6%)	\$17910.2m (38.4%)	\$59836.2m
Growth Rate p.a.	7.2%	8.8%	8.0%
Private 75	\$ 344.9m (11.9%)	\$ 2554.3m (88.1%)	\$ 2899.2m
99	\$ 2332.3m (8.9%)	\$23844.6m (91.1%)	\$26176.9m
Growth Rate p.a.	8.3%	9.8%	9.6%
Total 75	\$ 7354.2m (60.0%)	\$ 4905.9m (40.0%)	\$12260.1m
99	\$39185.1m (45.6%)	\$41754.8m (54.4%)	\$86013.1m
Growth Rate p.a.	7.2%	9.3%	8.5%
Private Share 75	4.7%	52.1%	23.6%
99	6.0%	57.1%	30.4%

Source: Canadian Institute for Health Information: National Health Expenditures in Canada, 1975-1999. Canadian Institute for Health Information: Ottawa, 1999.

Table 2: Canadian Population Size (000s), Distribution (%) and Rate of Growth by Age Group

Age Group	1999	2026	Average Annual Compound Rate of Growth
0-64	26,700.7 (87.6%)	28,445.6 (78.5%)	0.2%
65-74	2,130.4 (7.0%)	4,383.6 (12.1%)	2.7%
75-84	1,265.1 (4.1%)	2,451.2 (6.8%)	2.5%
>=85	395.1 (1.3%)	924.9 (2.6%)	3.2%
Total	30,491.3	36,205.3	0.6%

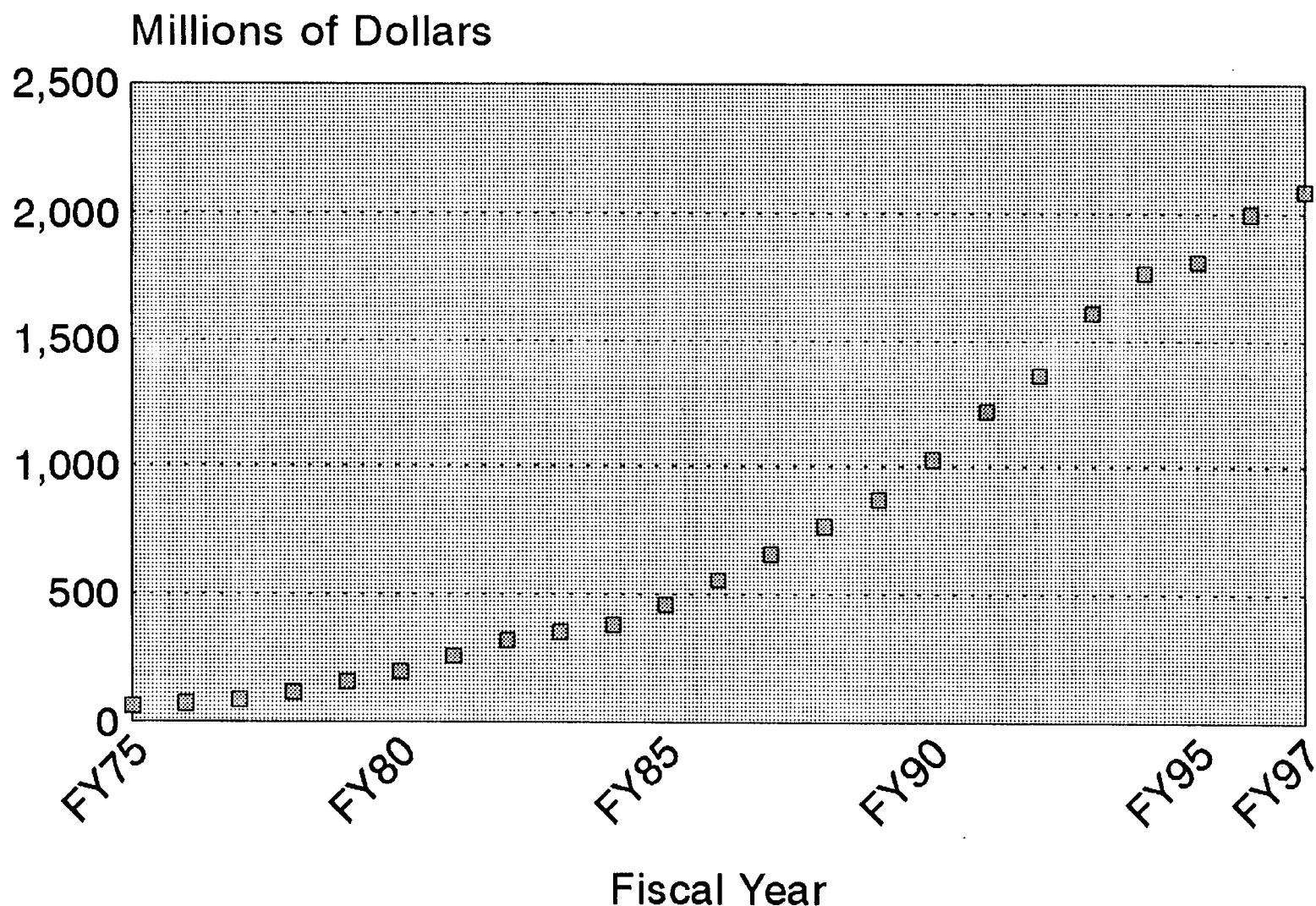
Source: Statistics Canada: Population Projections for 2026, July 1: Medium Growth Projections, www.statcan.ca, 2000.

Table 3: Actual and Projected Expenditures for Public Home Care Expenditures in Canada, and the Provinces and Territories.

	Actual Exp.	Projected Exp.	Funding Variance (%)
	FY97 Home Care Expenditures (Millions)	Population-Based Funding (PBF) (Millions)	$\frac{(\text{Projected}-\text{Actual}) \times 100}{\text{Actual}}$
Nfld	\$ 51.991	\$ 47.488	-8.7%
PEI	\$ 4.701	\$ 13.885	195.7%
NS	\$ 75.777	\$ 93.326	23.1%
NB	\$ 72.026	\$ 73.202	1.6%
Que	\$ 277.198	\$ 677.452	144.4%
Ont	\$1038.929	\$1038.929	0.0%
Man	\$ 103.640	\$ 117.587	13.5%
Sask	\$ 70.327	\$ 112.150	59.4%
Alta	\$ 149.318	\$ 223.730	49.8%
BC	\$ 244.113	\$ 373.793	53.1%
YK	\$ 1.427	\$ 1.452	1.8%
NWT	\$ 6.528	\$ 2.707	-58.5%
Canada	\$2095.975	\$2775.551	32.4%

Source: Policy and Consultation Branch: Public Home Care Expenditures 1975-76 to 1997-98: Fact Sheet. Health Canada: Ottawa, March 1998.

Figure 1: Public Home Care Expenditures in Canada, FY75-FY97



Source: Policy and Consultation Branch, Health Canada, March 1998.
www.hc-sc.gc.ca/datapcb/datahesa/homecare/homecare.htm, 1999.

Figure 2: Share of Public Home Care Expenditures in Public Health Expenditures, FY97

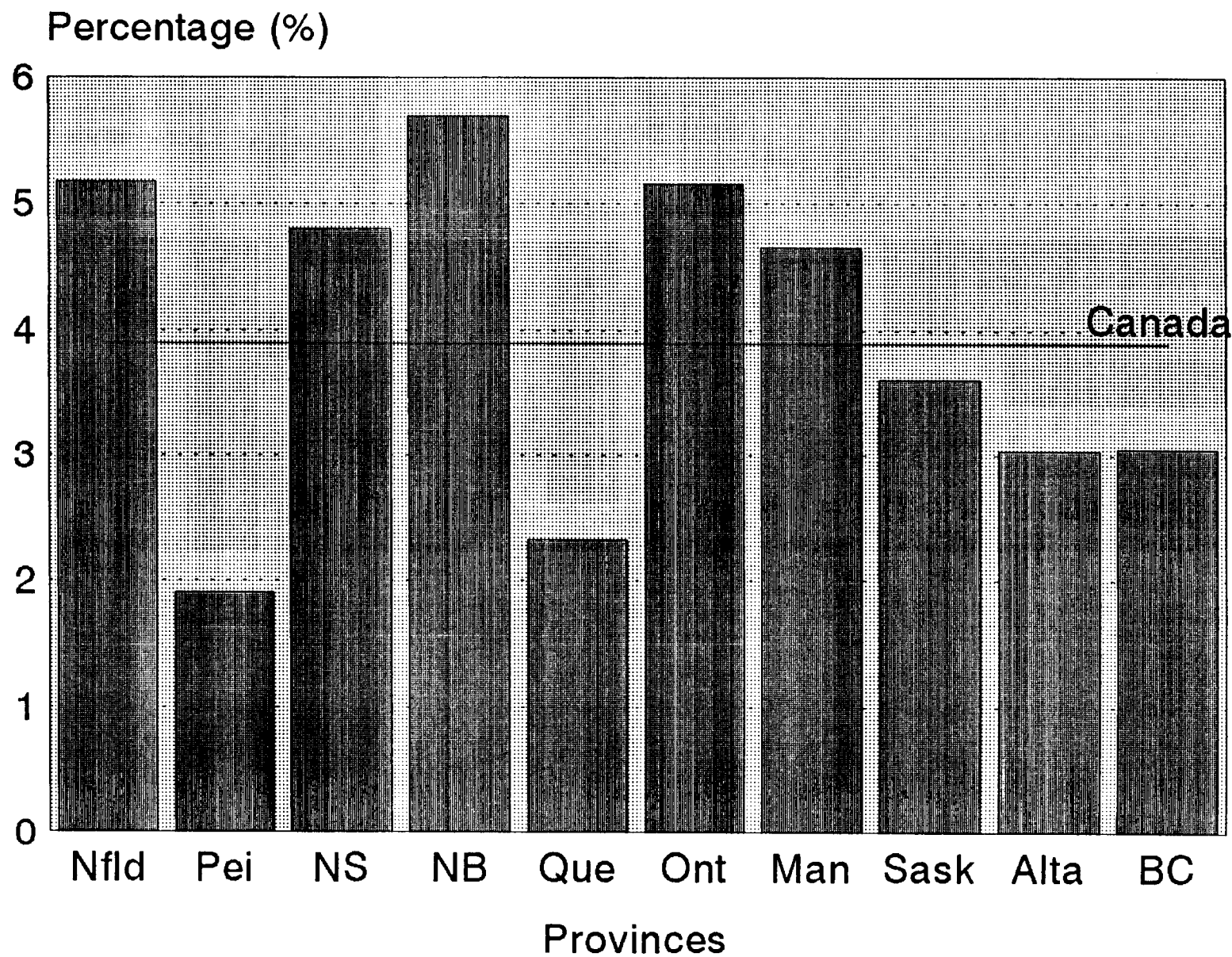


Figure 3: Public Home Care Expenditures Per Capita, FY97

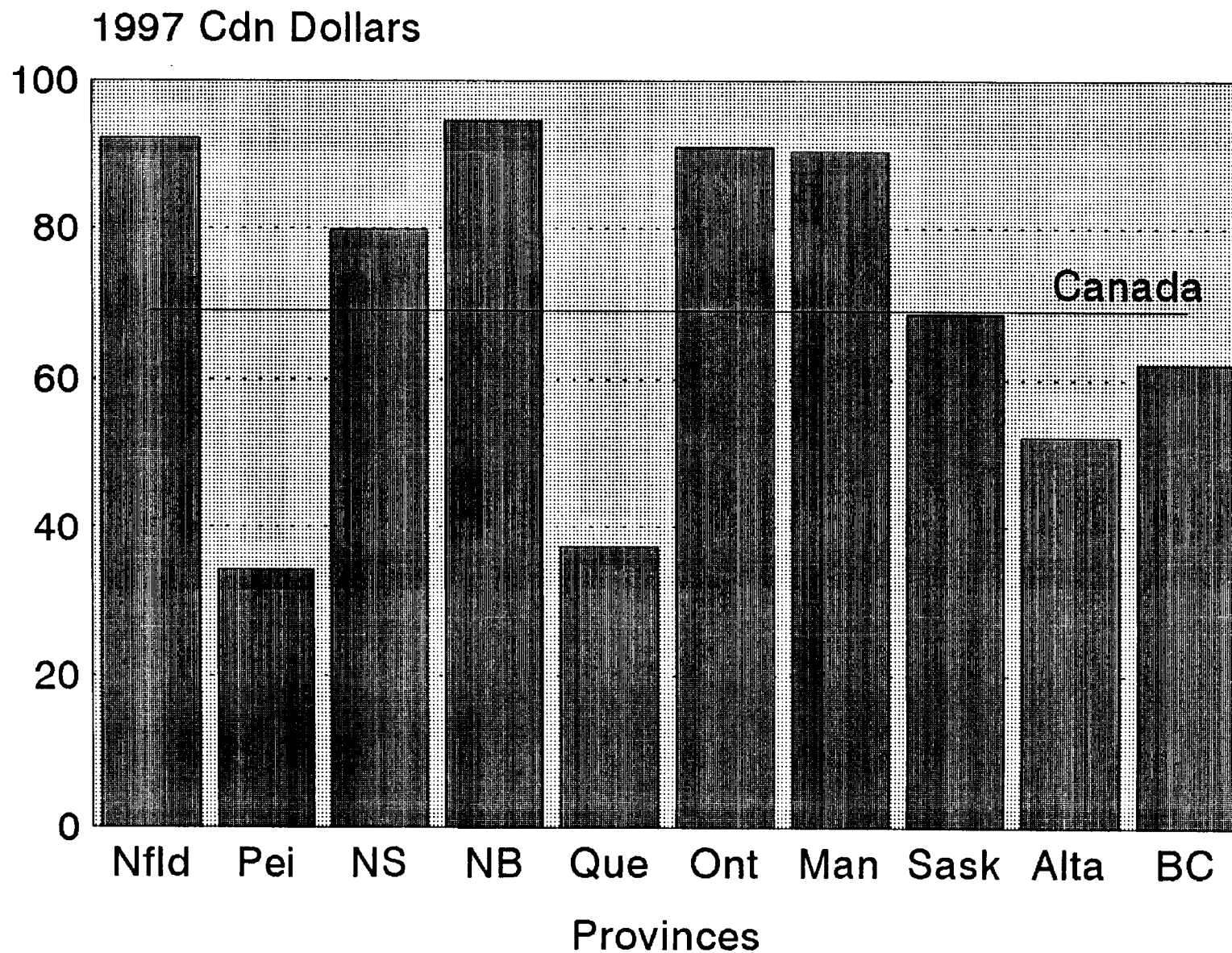


Figure 4: Age-Gender Distribution of Home Care Clients in Ontario, FY95

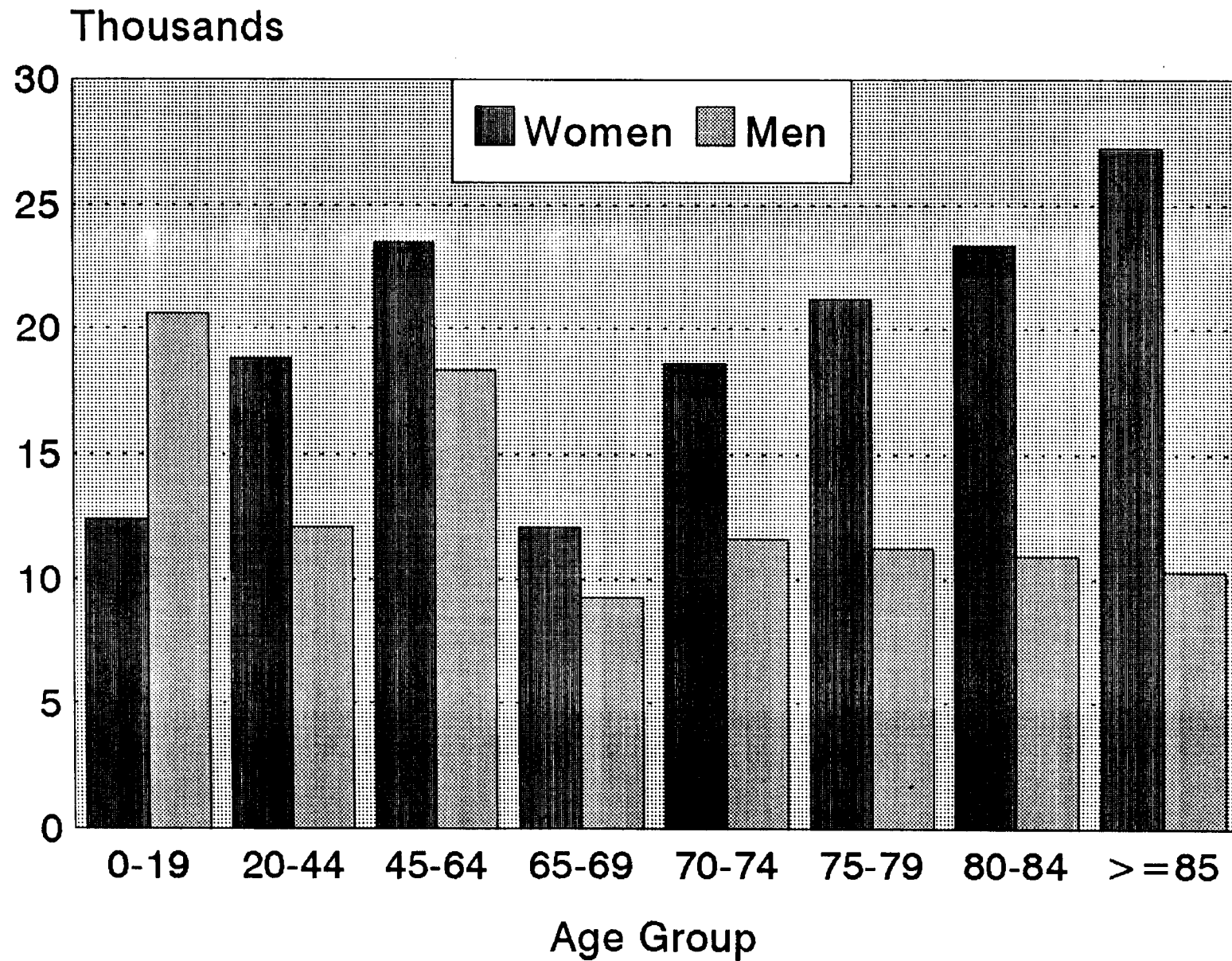


Figure 5: Home Care Utilization Rates by Age and Gender in Ontario, FY95

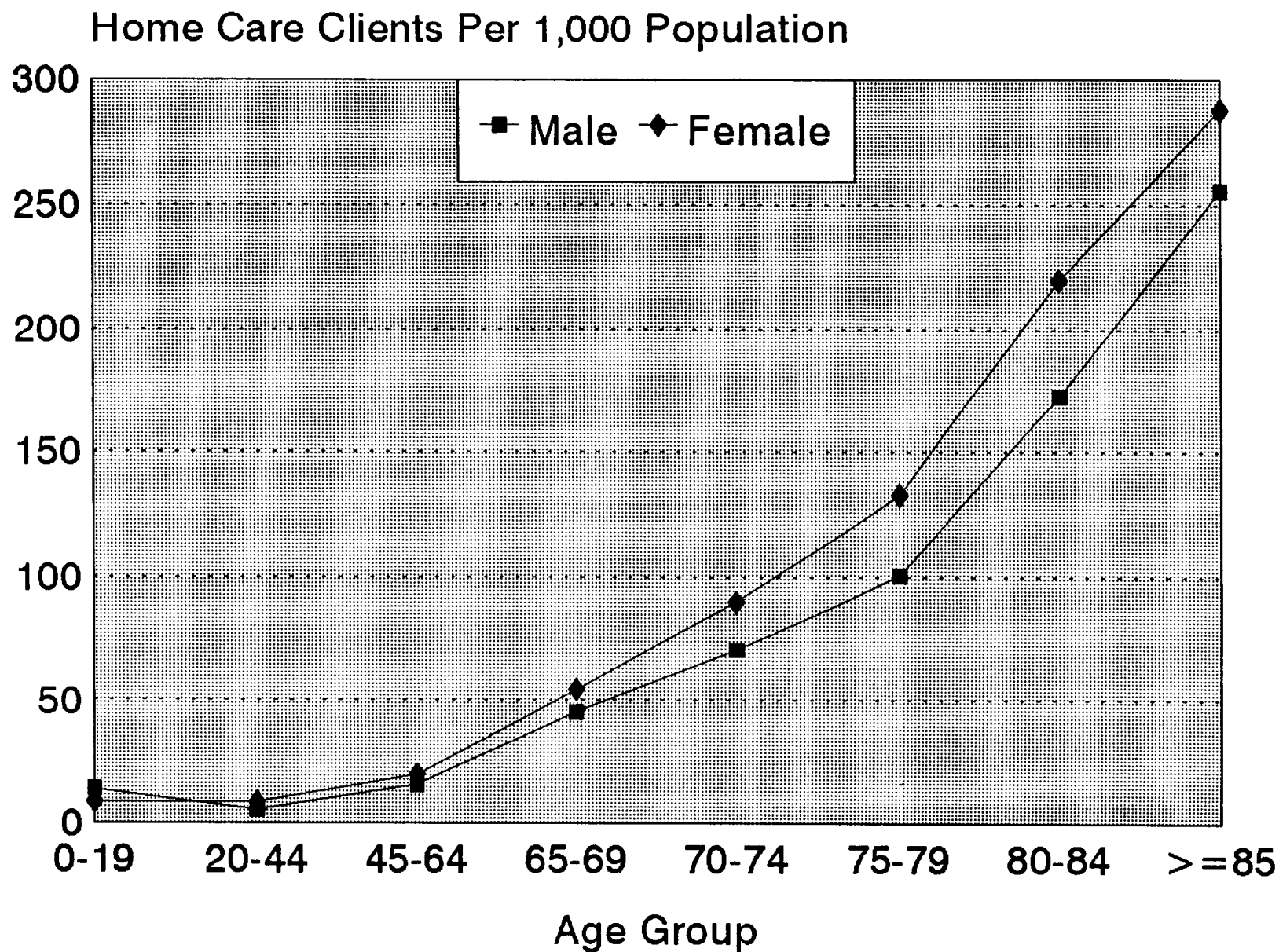


Figure 6: Intensity of Home Care Utilization, FY95

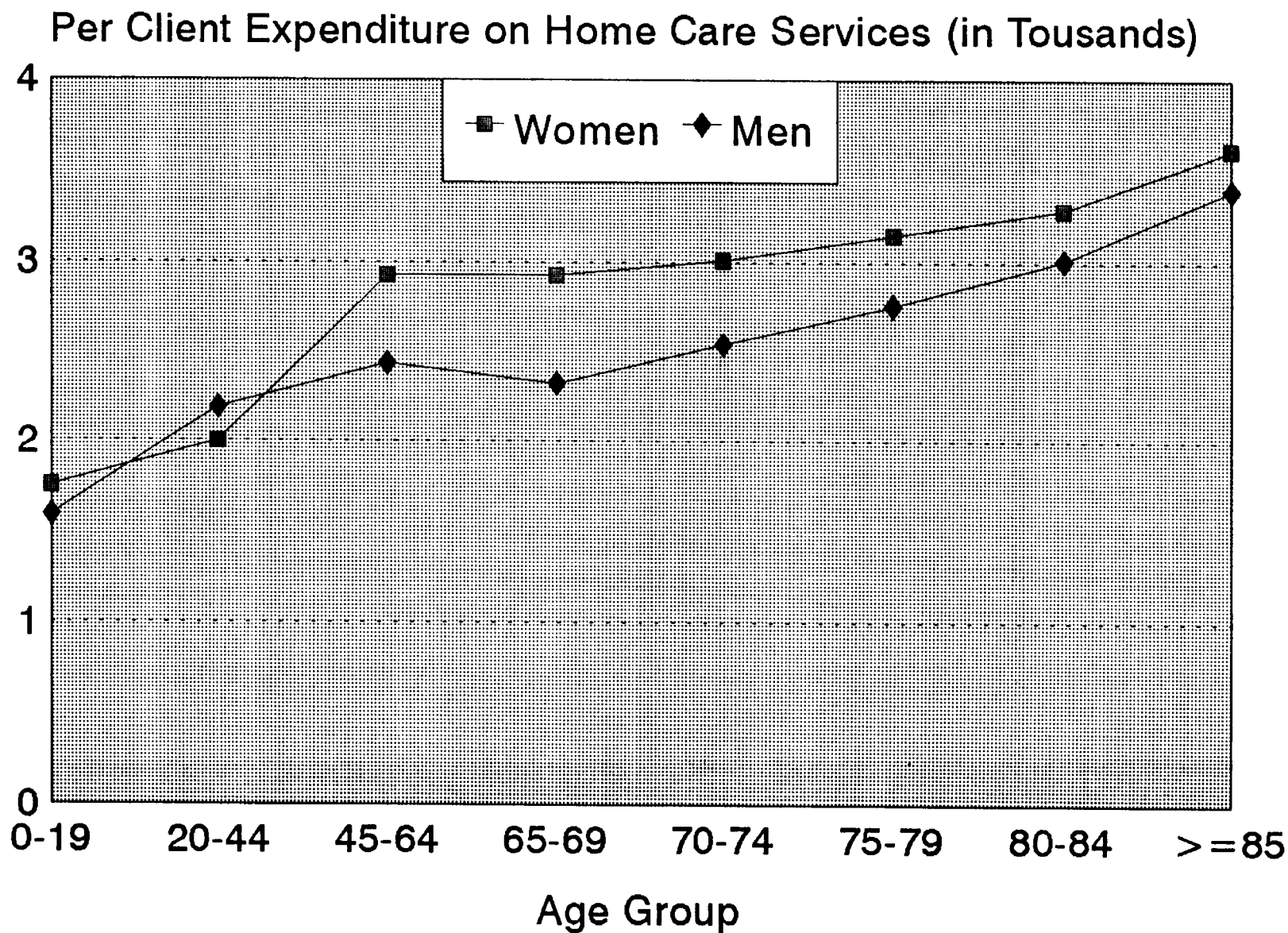


Figure 7: Share of the Population ≥ 80 Years Compared to the Share ≥ 65 Years

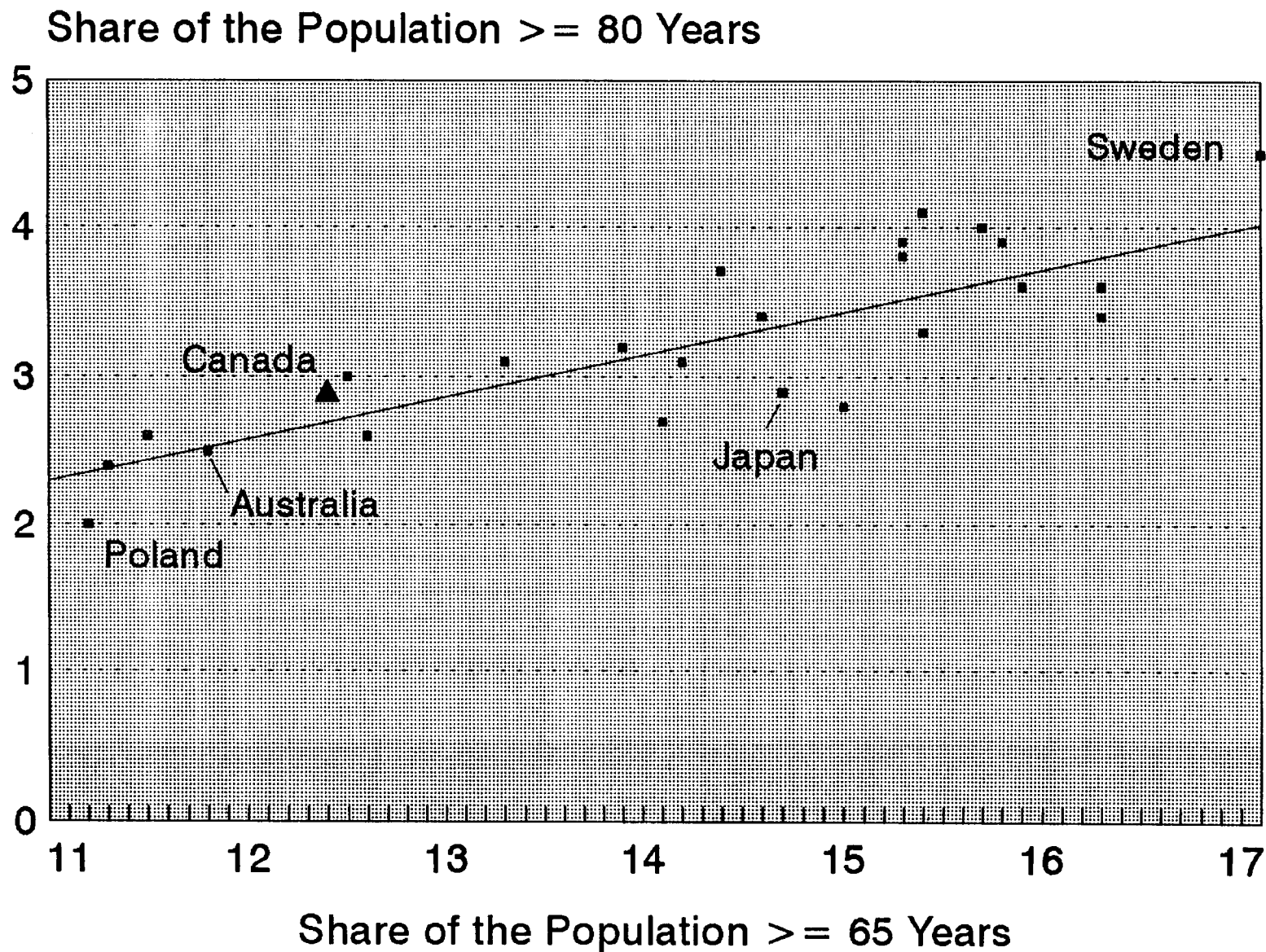
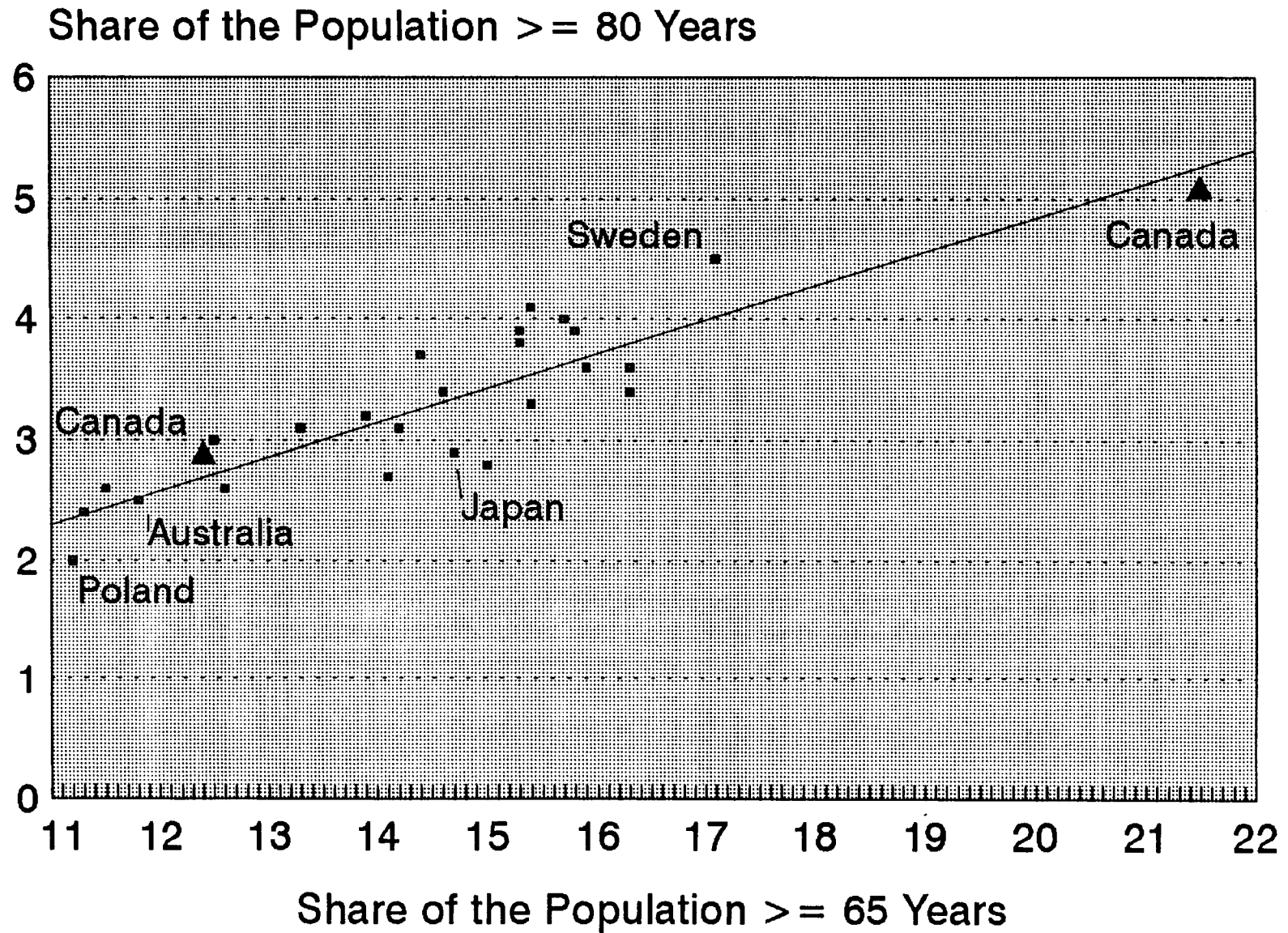


Figure 8: Share of the Population ≥ 80 Years Compared to the Share ≥ 65 Years



OECD for 1998, and Canadian Data for 1999 & 2026.